S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 9 1945

Registration District No. 42

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1000

State File No. 40619

Registrar's No. 1319

1. PLACE OF DEATH:

(a) County: Buchanan

(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: State Hosp. No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 yrs 5 1/2 mos (Specify whether years, months or days) In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Clinton

(c) City or town: Holt
(If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Cora Akes

3. (b) If veteran, name war:

3. (c) Social Security No.

4. Sex: fem

5. Color or race: Wh

6. (a) Single, widowed, married, divorced: Separated

6. (b) Name of husband or wife: John Akes

6. (c) Age of husband or wife if alive: Unknown Years

7. Birth date of deceased: Jan (Month) 7 (Day) 1897 (Year)

8. AGE: Years 47 | Months 11 | Days 24 | If less than one day: hr. min.

9. Birthplace: Oklahoma (City, town, or county) (State or foreign country)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Jim Pack
13. Birthplace: Tennessee (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Susie West
15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Hospital records

(b) Address:

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation Mountain

18. (a) Signature of funeral director: O. L. Martin

(b) Address: Plattsburg Mo

19. (a) 12-31-44 (Date received local registrar) (b) Reed J. Fickle (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 31 year 1944 hour 6 minute 25 A.M.

21. I hereby certify that I attended the deceased from March 1, 1944 to Dec. 30, 1944 that I last saw her alive on Dec. 30, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chronic myocarditis, auricular flutter, dropsy (95a)	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Epilepsy with psychosis	

Major findings:
Of operations: 93d
Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: Dora Hochdorf M.D. (M. D. or other)

Address: State Hosp. No 2 St. Joseph Date signed 12/31/44

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

.....,Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.