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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 1 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38411**  
Registrar's No. **2682**

Registration District No. **317** Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County St. Louis  
 (b) City or town St. Louis County  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Unknown  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether in this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
 (c) City or town St. Louis  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4031a Shenandoah Ave  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Howard W. Akers  
 3. (b) If veteran, name war No 3. (c) Social Security No. \_\_\_\_\_  
 4. Sex White 5. Color or race Male 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Vera 6. (c) Age of husband or wife if alive 36 years  
 7. Birth date of deceased July 5 1906  
 (Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 23  
 year 1945 hour 8 minute 30 AM.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_,  
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>4</u>	<u>18</u>	hr. _____ min. _____

Immediate cause of death Shotgun wound of left arm Duration \_\_\_\_\_  
 Due to Homicide  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

9. Birthplace Albin Mo  
 (City, town, or county) (State or foreign country)  
 10. Usual occupation Bartender  
 11. Industry or business Self

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy none  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
 12. Name James W Akers  
 13. Birthplace Missouri  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Mary Counts  
 15. Birthplace Missouri  
 (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) Homicide  
 (b) Date of occurrence Nov. 22nd, 1945  
 (c) Where did injury occur? St. Louis County, Mo.  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Unknown location  
 While at work? no (Specify type of place) (e) Means of injury firearm  
 23. Signature Donald J. Willmann (M.D. or other) Coroner 3  
 Address Dayton, Mo. Date signed 11/26/45

16. (a) Informant Alta E Vance  
 (b) Address 4119 Blaine Ave  
 17. (a) Burial (b) Date thereof 11 26 45  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Burial Valhalla Cem  
 18. (a) Signature of funeral director Kriegshauser  
 (b) Address 4228 So. Kingshighway  
 19. (a) 11-26-45 (b) Don E. Egan M.D.  
 (Date received local registrar) (Registrar's signature)

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

**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 Edwin D Mc Dermott  
[ Licensed Embalmer No. 3027  
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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 38411  
Registrar's No. 2687Registration District No. 317Primary Registration District No. 6076

## 1. PLACE OF DEATH:

- (a) County St. Louis  
 (b) City or town Rural  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 (Specify whether \_\_\_\_\_)
- In this community \_\_\_\_\_  
 years, months or days)

3. (a) PRINT  
FULL NAMEHoward W. Aker3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex W 5. Color or  
race M 6. (a) Single, widowed, married,  
divorced M6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased July 5  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
39 hr. \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2-18-46 (b) EB M. Garrison MD  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
 (If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
 year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19 \_\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

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?  
While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY 23

