

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 20, 1947

Registration District No. 130

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5463 A

State File No. 4582

Registrar's No. 29

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Strafford Rt. 2
(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 NAME William Ben Akin

3. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife Infant
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 24, 1946
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
0 2 14 hr. min.

9. Birthplace Greene Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business Infant

12. Name Columbus Akin

13. Birthplace Greene Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Workman

15. Birthplace Greene Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Columbus Akin

(b) Address Strafford Rt. 2,

17. (a) Burial (b) Date thereof 2 9 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bassville Mo,

18. (a) Signature of funeral director J.W. Klingner & Co.

(b) Address Springfield Mo.

19. (a) Feb-11-1947 (b) Samuel Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Strafford Rt. 2.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 8
year 1947 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from Jan 24 to Feb 2-8, 1947.
that I last saw him alive on Jan 3, 1947.
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

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)

Means of injury 0

23. Signature Samuel Jones (M. D. or other) MD

Address Springfield Mo Date signed 2-70-47

(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.....

Ogden Stone Jr.

Licensed Embalmer No. *4126*

P. O. Address.....

Springfield

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.