S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 15 1947

Registration District No. 1

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28192

Primary Registration District No. 3033

Registrar's No.

1. PLACE OF DEATH:
(a) County Laclede
(b) City or town Lebanon
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Wallace Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution few hrs. (Specify whether
In this community 1 yr
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Laclede
(c) City or town Lebanon
(If outside city or town limits, write "RURAL")
(d) Street No. 315 Garfield
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Lucille Aker
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife John William Aker
6. (c) Age of husband or wife if alive 20 years
7. Birth date of deceased July (Month) 17 (Day) 1927 (Year)

8. AGE: Years 20 | Months — | Days 18 | If less than one day hr. min.

9. Birthplace Conway Laclede Co. Mo. (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Joseph Kelsey
13. Birthplace Miller Co. Mo. 0 (City, town, or county) (State or foreign country)
14. Maiden name Pearl Jones
15. Birthplace Wright Co. Mo. ? (City, town, or county) (State or foreign country)
16. (a) Informant John William Aker
(b) Address Lebanon Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-47 (Month) (Day) (Year)
(c) Place: burial or cremation Graceland Cemetery
18. (a) Signature of funeral director W. E. Holman
(b) Address Lebanon Mo.
19. (a) Sept 6, 1947 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 5 year 1947 hour 13 minute P. M.

21. I hereby certify that I attended the deceased from 19-Feb 19 47 to 5-Aug 19 47 that I last saw h alive on 5 Aug 19 47 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Hemorrhage, Post Partum - Severe	
Due to complete prolapse of uterus, following	
Normal delivery, no instruments or medication, except Pitocin to delivery. P.	
Other conditions (Include pregnancy within 3 months of death) Irregularly checked & many things	
Major findings: Of operations apparently normal	
Of autopsy	

PHYSICIAN

Underline the cause of 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 J. Summers (M.D. or other)
Address Lebanon Mo Date signed 8-14-47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

9/12/47

Received _____

Laclede County Health Unit

File No. 8-47-141

Date Filed 9/13/47

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 Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon Mo.

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.