

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36662

State File No. _____

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>1073</u>	
1. PLACE OF DEATH a. COUNTY <u>Greene</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Springfield</u> c. LENGTH OF STAY (In this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Springfield Baptist</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Greene</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural 2nd Jackson</u> <u>8390</u> d. STREET ADDRESS (If rural, give location) <u>Rt. 3 Strafford</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>James</u> b. (Middle) <u>Oscar</u> c. (Last) <u>Akin</u>		4. DATE OF DEATH (Month) <u>Dec.</u> (Day) <u>2</u> (Year) <u>1950</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 26 1885</u>	
9. AGE (In years last birthday) <u>65</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Jackson Akin</u>		13b. MOTHER'S MAIDEN NAME <u>Lucinda Bass</u>		14. NAME OF HUSBAND OR WIFE <u>Carrie Akin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Carrie Akin</u>		ADDRESS <u>Strafford</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial degeneration</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pneumonitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>One Hour</u> <u>3 months</u> <u>3 days</u>	
19a. DATE OF OPERATION <u>No</u>		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>11/28, 1950</u> , to <u>12/2, 1950</u> , that I last saw the deceased alive on <u>12/2, 1950</u> , and that death occurred at <u>6:40 p. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>G. H. Fretts M.D.</u>		23b. ADDRESS <u>Strafford Mo</u>		23c. DATE SIGNED <u>12/5/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-4-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>25mi. Northeast Springfield</u>	
DATE REC'D BY LOCAL REG. <u>12-6-50</u>		REGISTRAR'S SIGNATURE <u>W. E. Handley M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Klingner & Co.</u>		ADDRESS <u>Springfield</u>	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY--USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Signed _____
Student Embalmer

Licensed Embalmer No. 4071

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.