

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **29008**

AUG 25 1952

BIRTH NO.		REG. DIST. NO. 279		PRIMARY REG. DIST. NO. 5957		Registrar's No. 16			
1. PLACE OF DEATH a. COUNTY Pike				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Pike					
b. CITY (If outside corporate limits, write RURAL and give township) Rural - Franeyville		c. LENGTH OF STAY (In this place) 75 yrs		c. CITY (If outside corporate limits, write RURAL and give township) Rural		01220			
d. FULL NAME OF HOSPITAL OR INSTITUTION 1/2 Mile North of Eolia				d. STREET ADDRESS (If rural, give location) 1/2 Mile North of Eolia					
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Robert c. (Last) AKERS		4. DATE OF DEATH (Month) (Day) (Year) August 10 1952							
5. SEX MO		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 25, 1876			
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and State or Foreign Country) Lincoln County, Mo			
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William H. Akers		13b. MOTHER'S MAIDEN NAME Clara E. Huckstep		14. NAME OF HUSBAND OR WIFE Flossie Maye Akers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Flossie Maye Akers		ADDRESS Eolia, Mo			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) congestive heart failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) rheumatic heart disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 6 mon.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 416X		20. AUTOPSY? YES ☐ NO ☒					
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) m. 11-27-1952		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 11-27-1952 to 8-10-1952 that I last saw the deceased alive on 8-10-1952 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.									
23a. SIGNATURE John H. Hooker, M.D.				23b. ADDRESS Clarksville, Mo.		23c. DATE SIGNED 8-11-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 12, 1952		24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) Eolia, Missouri			
DATE REC'D BY LOCAL REG. 8-23-52		REGISTRAR'S SIGNATURE John P. McRae		25. FUNERAL DIRECTOR'S SIGNATURE The Rev. Funeral Service		ADDRESS Eolia			

(Licensed Embalmer's Statement on Reverse Side)

John P. McRae**Mo**

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, ~~only~~ _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

George O. Wagner

Licensed Embalmer No. *3773*

P. O. Address *Louisiana 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.