

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9009

State File No.

FILED APR 6 1953

BIRTH NO. _____		REG. DIST. NO. <u>47</u>		PRIMARY REG. DIST. NO. <u>3008</u>		Registrar's No. <u>136</u>			
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).					
a. COUNTY <u>Callaway</u>		a. STATE <u>Mo</u>		b. COUNTY <u>Jackson</u>					
b. CITY (If outside corporate limits, write RURAL and give township) <u>Fulton</u>		c. LENGTH OF STAY (in this place) <u>194 Yrs</u>		c. CITY OR TOWN <u>Little BLUE</u>		d. Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) <u>State Hos # 1</u>				e. STREET ADDRESS (If rural, give location) <u>Jackson Co Home 7000</u>					
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)						
a. (First) <u>FANNY</u> - <u>M</u> - <u>ACKINSON</u>			b. (Middle)			c. (Last)			
5. SEX <u>f</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>DK</u>		8. DATE OF BIRTH <u>1889</u>			
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months		IF UNDER 2 WKS. Hours		IF UNDER 2 WKS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hush</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>DK</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>DK</u>			
12. CITIZEN OF WHAT COUNTRY? <u>DK</u>			13a. FATHER'S NAME <u>DK</u>		13b. MOTHER'S MAIDEN NAME <u>DK</u>		14. NAME OF HUSBAND OR WIFE <u>DK</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>DK</u>			16. SOCIAL SECURITY NO. <u>DK</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Social Worker Senthor # 2</u>			ADDRESS <u>Kand City, MO</u>	
18. CAUSE OF DEATH			MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tubercular pneumonia</u>						
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES						
			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.						
			DUE TO (b) _____						
			DUE TO (c) _____						
			II. OTHER SIGNIFICANT CONDITIONS						
			Conditions contributing to the death but not related to the disease or condition causing death. <u>dementia praecox - hebephrenic</u>						
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
								<u>490X</u>	
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) (Min.)			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>2-23</u> , 19 <u>53</u> , to <u>4-1</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>4-1</u> , 19 <u>53</u> , and that death occurred at <u>5:30</u> pm., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>J. Henry Fowler MD</u>				23b. ADDRESS <u>State Hos Fulton Mo</u>			23c. DATE SIGNED <u>4-1-53</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>4-4-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>anatomical Board</u>		24d. LOCATION (City, town, or county) (State) <u>Columbia Mo</u>			
DATE REC'D BY LOCAL REG. <u>Apr. 4-1953</u>		REGISTRAR'S SIGNATURE <u>Maretha Lawrence</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. O. Roberts</u>		ADDRESS <u>Columbia Mo</u>			

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

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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..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.