

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032508  
STATE FILE NUMBER

FILED SEP 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4117

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3604 THE PASEO</b>		Length of stay in 1b <b>65 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>3604 THE PASEO</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>LOU</b> Middle <b>ELLA</b> Last <b>AKERS</b>	4. DATE OF DEATH Month <b>AUGUST</b> - Day <b>27</b> - Year <b>1958</b>
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5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 8, 1894</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (City and state or country) <b>ROCKY MOUNT, VIRGINIA</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>WILLIAM AKERS</b>	13b. MOTHER'S MAIDEN NAME <b>SALLY F. HICKMAN</b>	14. NAME OF HUSBAND OR WIFE -----
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	16. SOCIAL SECURITY NO. <b>486-01-0439</b>	17. INFORMANT <b>Nephew</b> Address <b>Frank Fuller Kansas City, Mo. 64101</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Colitis ulcerative - acute (Arteriosclerotic) terminal mesencephalic hemorrhage</b>		<b>4 Mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b) <b>Arteriosclerotic heart disease</b>		<b>1 hr.</b>
DUE TO (c) <b>Arteriosclerotic heart disease</b>		<b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in Part I. <b>Arteriosclerosis generalized Mod.</b>		WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.) <b>None</b>
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20c. TIME OF INJURY Hour a.m. p.m. <b>None</b>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. CITY, TOWN, OR LOCATION <b>5722 102nd</b>	COUNTY	STATE
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21. I attended the deceased from **March 1958** to **8-27-58** and last saw her <sup>her</sup> alive on **8/27/58**  
Death occurred at **6:54 P.M.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Harold A. Budke</b> (Degree or title)	22b. ADDRESS <b>1019 ARGYNE Bldg.</b>	22c. DATE SIGNED <b>8-28-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>AUG-30-1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WELLSVILLE CEMETERY</b>	23d. LOCATION (City, town, or County) (State) <b>WELLSVILLE KANSAS</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMB'S Sons</b>	ADDRESS <b>1231 BASHIN CREEK KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>8-29-58</b>	26. REGISTRAR'S SIGNATURE <b>Neva Minshall</b>
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

Harold A. Budke USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

72

4421

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 .....

*C. D. Nelson*

Licensed Embalmer No. 4421

P. O. Address Kansas City

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.