

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-015939

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 127 Primary Registration District No. 3040 Registrar's No. 95

VS 300
Rev. 4/59

6595
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>LIVINGSTON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CHARITON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u> | | Length of stay in lb <u>24 hrs</u> | c. CITY OR TOWN <u>SUMNER</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City Hospital</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>RELLA</u> Middle <u>AKERS</u> Last <u>AKERS</u> | | | 4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>62</u> |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>white</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 12 1886</u> |
| 9. AGE (last birthday) <u>75</u> | | IF UNDER 1 YEAR Months <u>9</u> Days <u>11</u> | IF UNDER 24 HR Hours <u>11</u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | 11. BIRTHPLACE (City and state or country) <u>Taylor Co Iowa</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>SIMEON Beemer</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>ALICE Whitecotton</u> | | 14. NAME OF HUSBAND OR WIFE <u>BEN AKERS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Ben AKERS SUMNER MO</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> DUE TO (b) <u>Acute Congestive Heart Failure</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Ch. Microcytic anemia</u> | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input 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.) | |
| 20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u> | Month, Day, Year | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY STATE |
| 21. I attended the deceased from <u>4-22-62</u> to <u>4-23-62</u> and last saw her <u>alive on 4-22-62</u> Death occurred at <u>4:45 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>J. M. Dowd, M.D.</u> (Degree or title) | | 22b. ADDRESS <u>Chillicothe MO</u> | 22c. DATE SIGNED <u>4-25-62</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>4/25/62</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lakeside</u> | 23d. LOCATION (City, town, or county) (State) <u>SUMNER MO</u> |
| 24. FUNERAL DIRECTOR <u>J. L. Hoipard</u> ADDRESS <u>MENON MO</u> | | 25. DATE RECD. BY LOCAL REG. <u>4/25/62</u> | 26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u> |

USE BLACK INK OR TYPEWRITER RIBBON

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 Billie C. Londee

Licensed Embalmer No. 4980

P. O. Address Mendon, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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