WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Benton

Township West White or Village or City (NO. St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number]

Registration District No. 60

Primary Registration District No. 5095

File No. 19450

Registered No. 16

FULL NAME Mathias Acker

PERSONAL AND STATISTICAL PARTICULARS		
SEX: Male	COLOR OR RACE: White	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed
DATE OF BIRTH: July (Month) 7 (Day) 1840 (Year)		
AGE: 77 yrs. 11 mos. 23 ds.	If LESS than 1 day, ...hrs. or ...min.?	
OCCUPATION (a) Trade, profession, or particular kind of work: Farmer		
(b) General nature of industry, business, or establishment in which employed (or employer): Gov'd		
BIRTHPLACE (City or town, State or foreign country): Germany		
PARENTS — NAME OF FATHER: Unknown		
BIRTHPLACE OF FATHER (City or town, State or foreign country): Unknown		
MAIDEN NAME OF MOTHER: Unknown		
BIRTHPLACE OF MOTHER (City or town, State or foreign country): Unknown		

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W J Acker

(ADDRESS) Windsor Mo

Filed July 1 1918 W. Jones REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June (Month) 30 (Day) 1918 (Year)

I HEREBY CERTIFY, that I attended deceased from June 18, 1918, to June 30, 1918, that I last saw him alive on June 30, 1918, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

46B (Duration) 40 yrs. mos. ds.

Contributory (SECONDARY) 8

(Duration) yrs. 8 mos. ds.

(Signed) R F Jennings M. D.

July 1, 1918 (Address) Shawnee

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Windsor Mo	July 1 1918
UNDERTAKER	ADDRESS
W. E. Huston	Windsor Mo

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....(NO.....,.....St.;.....Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No..... File No.....

Primary Registration District No..... Registered No.....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

.....(Month) .....(Day), 1.....(Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

BIRTHPLACE
(City or town, State or foreign country).....

PARENTS

NAME OF FATHER.....

BIRTHPLACE OF FATHER
(City or town, State or foreign country).....

MAIDEN NAME OF MOTHER.....

BIRTHPLACE OF MOTHER
(City or town, State or foreign country).....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed....., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

.....(Month) .....(Day), 191.....(Year)

I HEREBY CERTIFY, that I attended deceased from....., 191....., to....., 191.....,

that I last saw h.....alive on....., 191.....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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