

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

Do not use this space.

30578

3320

**1. PLACE OF DEATH**

County Jackson  
Township Kearney  
City Keosauqua (No. St Lukes)

Registration District No. 222  
Primary Registration District No. 222

File No. 30578  
Registered No. 3320  
St. St Lukes Ward 1

**2. FULL NAME**

Storvall Jackson Ackerly  
(a) Residence No. 3320 St. St Joe Mo  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mina Ackerly

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 9 1866

7. AGE YEARS MONTHS DAYS 61 8 22 LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Hog buyer  
(b) General nature of industry, business, or establishment in which employed (or employer) Arthur Packing Co  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

10. NAME OF FATHER John Ackerly

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Va

12. MAIDEN NAME OF MOTHER Victoria White

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ky

14. INFORMANT (Address) C. W. Brooks  
Chi Lee

15. FILED 9/17 28 M. M. Crowe REGISTRAR  
Asst

**2. MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 1 1928

17. I HEREBY CERTIFY, That I attended deceased from Sept 17, 1928, to Sept 16, 1928, that I last saw him alive on Sept 10, 1928, and that death occurred, on the date stated above, at 10 P m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Inter ventricular hemorrhage  
Arteriosclerosis  
(SECONDARY)  
(duration) 1 yrs. 2 mos. 2 ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH, DATE OF Mo

19. DID AN OPERATION PRECEDE DEATH? No DATE OF Mo  
WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) H. R. Bryfogle, M. D.  
(Address) 718 Medical Bldg

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL St Joe Mo DATE OF BURIAL 9-17 1928

20. UNDERTAKER Mrs C. L. Foster ADDRESS Keosauqua Mo

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.

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

