

FILED DEC 9 1943

Registration District No. _____

Primary Registration District No. **3059**

Registrar's No. **128**

1. PLACE OF DEATH:

(a) County **St. Francois**

(b) City or town **Boone Grove**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1 Church St.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether)

In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Francois**

(c) City or town **Boone Grove**
(If outside city or town limits, write "RURAL")

(d) Street No. **Church St**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **WILLIAM ALEXANDER AKERS**

3. (b) If veteran, name war **V**

3. (c) Social Security No. **None**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **29th** year **1943** hour **9** minute **55 A. M.**

21. I hereby certify that I attended the deceased from **Dec 9th** 1943 to **Oct 29th** 1943 that I last saw him alive on **Oct 15th** 1943 and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**

4. Sex **M** 5. Color or race **W**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Helicia Akers**

6. (c) Age of husband or wife if alive **69** years

7. Birth date of deceased **Oct. 10 1869**
(Month) (Day) (Year)

8. AGE: Years **74** Months **0** Days **19** If less than one day _____ hr. _____ min.

9. Birthplace **Wythe Co. Virginia**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **John Akers**

13. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

14. Maiden name **Guenda Hillman**

15. Birthplace **Virginia**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs William Akers**

(b) Address **Boone Grove Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **11-2-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Francois Memorial**

18. (a) Signature of funeral director **Geoffrey H. Co**

(b) Address **319 Bonham Boone Grove**

19. (a) **Nov. 5, 1943** (Date received local registrar) (b) **Byrdie Buknester** (Registrar's signature)

Duration _____

Due to **Hypertension - gradual debility**

Due to _____

Other conditions (Include pregnancy within 3 months of death) **gza**

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury **9**

23. Signature **B. M. ...** (M.D. or other) **98**

Address **Boone Grove Mo** Date signed **12-1-43**

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

24
2
1

RECEIVED

District Health Officer No. 4
District File Number 1243-300
Date Filed 12-8-43

252A

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 _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. 3706

P. O. Address Some New 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 this body is not embalmed, fact should be so stated above.