. S. No. 2
OM—8-43
v. 5-17-39
I X37823

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

96
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 5 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25604 OV

State File No.

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1640

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Lemay
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 412 Wachtel
(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. Louis 96
(c) City or town Lemay 0
(If outside city or town limits, write "RURAL") 0
(d) Street No. 412 Wachtel Ave
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country ..... D

3. (a) PRINT FULL NAME Laura A. Aikins
3. (b) If veteran, name war no
3. (c) Social Security No. no
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Albert S. Aikins
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Aug. 23rd 1869 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
74	11	8	hr. min.

9. Birthplace Plattville Wisconsin (City, town, or county) (State or foreign country)
10. Usual occupation House wife
11. Industry or business
FATHER
12. Name Christopher Williams
13. Birthplace Unk Tennessee (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name Martha Strong
15. Birthplace Charleston So. Carolina (City, town, or county) (State or foreign country)
16. (a) Informant Albert S. Aikins
(b) Address 412 Wachtel Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-44 (Month) (Day) (Year)
(c) Place: burial or cremation Sullivan Missouri
18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.
19. (a) AUG 3 - 1944 (Date received local registrar) (b) E. G. McGavran, M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31st year 1944 hour 8.30 minute P. M.
21. I hereby certify that I attended the deceased from Oct 1943 to July 31 1944 that I last saw her alive on July 31 1942 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	5 yrs
Nephritis chronic	12 yrs
Due to ~~Edema~~ uremia	3 days
with ascites and	
Due to Edema	1 wk.

Other conditions ..... (Include pregnancy within 3 months of death)

Major findings:
Of operations .....
Of autopsy .....

131 Dr

PHYSICIAN
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature J. G. White (Sign in ink or other) D.O.
Address 458 Lemay Ferry Rd Date signed 8-1-44

(Licensed Embalmer's Statement on Reverse Side)

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.....

P. O. Address.....

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.