No. 2
-5-43
-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27616

Registered District No. 13 FILED SEP 9 1944 Primary Registration District No. 5375 Registrar's No. 225

1. **PLACE OF DEATH:**
(a) County Dekalb
(b) City or town Rural Dallas Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Rural Dallis Twp /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community Entire Life
(Specify whether years, months or days)

2. **USUAL RESIDENCE OF DECEASED:** 32
(a) State Mo (b) County Dekalb 0
(c) City or town Rurial Dallas Twp
(If outside city or town limits, write "RURAL") 0
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME Maggie M. Ackley

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov (Month) I8 (Day) I875 (Year)

8. AGE: Years 68 | Months 8 | Days 22 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) 0

10. Usual occupation House Keeper

11. Industry or business

MOTHER FATHER

12. Name Samuel Ackley

13. Birthplace (City, town, or county) NY (State or foreign country) /

14. Malden name Mariemna Brown

15. Birthplace (City, town, or county) Ind (State or foreign country) /

16. (a) Informant Girtrude Ackley
(b) Address Maysville, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/I2/44 (Month) (Day) (Year)
(c) Place: burial or cremation Fagrport, Mo

18. (a) Signature of funeral director G. Bronner
(b) Address Pattonsburg, Mo

19. (a) 8-25-1944 (Date received local registrar) (b) John Clarke (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 8 day IO
year 44 hour II minute A. M.

21. I hereby certify that I attended the deceased from May 13, 1944, to Aug 10, 1944, that I last saw her alive on Aug 10, 1944, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Occlusion	—
Due to: Arteriosclerosis	10 yrs?
Due to:	
Other conditions: Cerebral Hemmorrhage (Include pregnancy within 3 months of death)	4 months ago

PHYSICIAN

Major findings:
Of operations 94a
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

23. Signature Dr. Harold Fowler (M. D. or other) M.D.
Address Maysville, Mo Date signed 8-12-44

1378 (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 G S Gomer

Licensed Embalmer No. 2857

P. O. Address Pattonsburg, 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.

No. 2B
—5-43
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

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

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town ____
(If outside city or town limits, write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME Maggie M. Ackley
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife ____
6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Nov. (Month) 16 (Day) 1875 (Year)

8. AGE: Years 68 | Months 8 | Days ____ | If less than one day: hr. ____ min.

9. Birthplace E. DeKalb (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) ____ (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) ____ (State or foreign country)

16. (a) Informant ____
(b) Address ____

17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director ____
(b) Address ____

19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 16 year 1943 at 10 A.M. minute ____ M.

21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h__ alive on ____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ____	
Due to ____	
Due to ____	
Other conditions ____ (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

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 ____ (M. D. or other) ____
Address ____ Date signed ____

SUDDEN ILLNESS

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