

No. 2
M-543
5-17-39
I X36671

State File No. _____

FILED FEB 16 1945 318

1003

Registrar's No. 1150

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Brothers Hospital
(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
(c) City or town Lemay
(If outside city or town limits, write "RURAL")
(d) Street No. 412 Wachtel
(If rural, give location) NR 00
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Albert S. Aikins

3. (b) If veteran,

name war Nil

3. (c) Social Security

No. None

4. Sex

Male

5. Color or race

White

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

Widower

6. (b) Name of husband or wife

Laura Aikins

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

years _____

7. Birth date of deceased

January
(Month)

12
(Day)

1867
(Year)

8. AGE:

Years

Months

Days

If less than one day

78

0

20

hr. _____ min.

9. Birthplace

Readstown

Wisconsin

(City, town, or county)

(State or foreign country)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Ely Aikins

13. Birthplace

Unknown

Ohio

(City, town, or county)

(State or foreign country)

14. Maiden name

Mary Harding

15. Birthplace

Philadelphia

Pa.

(City, town, or county)

(State or foreign country)

16. (a) Informant

Mrs. Ruth Marshall

(b) Address

412 Wachtel

17. (a)

Burial

(Burial, cremation, or removal)

(b) Date thereof

2-4-45

(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)

FEB 5 1945

(Date received local registrar)

J. F. Medical

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 2
year 1945 hour 5 minute 05 A.M.

21. I hereby certify that I attended the deceased from Jan 20
1945 to Feb 2 1945

that I last saw him alive on 2-2-45 and that death occurred on the date and hour stated above.

Immediate cause of death
ac dilation of head
(1) chronic card. & vascular
(2) chron. nephriti

Duration

3 day

Other conditions: hypertrophy of prostate
(Include pregnancy within 6 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?

While at work? _____

(Specify type of place)

(e) Means of injury _____

23. Signed Ernie J. Creel (M. D. or other) _____
Address 748 Lemay, St. Louis Date signed 2-3-45

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

0
1
9

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.....

Albert W. Kaye

Licensed Embalmer No.....

1861

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.