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DEPARTMENT OF COMMERCE
BUREAU OF VITAL STATISTICS
FILED MAR 21 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8535**
Registrar's No. **1120**

Registration District No. **149** Primary Registration District No. **1002**

1. PLACE OF DEATH:
(a) County **JACKSON**
(b) City or town **KANSAS CITY**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ROBINSON CLINIC
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 HOURS**
(Specify whether
In this community **20 yrs.**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MISSOURI** (b) County **JACKSON**
(c) City or town **Center City, Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **8619 INDEPENDENCE AVENUE**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **1**

3. (a) PRINT FULL NAME **MRS. PEARL K. ACKER**
(b) If veteran, name war **No**
(c) Social Security No. **# unk**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **MARCH** day **8TH**
year **1945** hour **5** minute **30 P. M.**

4. Sex **FEMALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
(b) Name of husband or wife **MR. LESTER F. COX**
6. (c) Age of husband or wife if alive **33** years
7. Birth date of deceased **MAY 18 1912**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **19** to **19**
that I last saw h. **alive**
and that death occurred on the date and hour stated above.

8. AGE: Years **32** Months **9** Days **20**
If less than one day _____ hr. _____ min.

Immediate cause of death **Crown Anemia**
Due to **pending investigation**
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **EMPLOYEE**
11. Industry or business **LAKE CITY ORDNANCE PLANT**
12. Name **CHARLES ACKER, SR.**
13. Birthplace **INDIANA**
(City, town, or county) (State or foreign country)
14. Maiden name **NELLIE MORAN**
15. Birthplace **IOWA**
(City, town, or county) (State or foreign country)

PHYSICIAN
Major findings:
Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

16. (a) Informant **MR. LESTER F. COX**
(b) Address **8619 INDEPENDENCE**
17. (a) **BURIAL** (b) Date thereof **MARCH 12 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **FLORAL HILLS CEMETERY**
18. (a) Signature of funeral director **W. H. Newcomer's Son**
(b) Address **1401 BRUSH CREEK BLVD.**
19. (a) **3-10-45** (b) **T. E. Brown**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **123**
(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 **James H. ...** (M. D. or other) **3**
Address **1424 ...** Date signed **3-7-45**

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

MOTHER FATHER

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 Ernie M. Calhoun

Licensed Embalmer No. 3506

P. O. Address Kemo.

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.

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 1120

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town H.C.
(c) Name of hospital or institution: Robinson Clinic
(d) Length of stay: In hospital or institution.....
In this community.....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town.....
(d) Street No.....
(e) Citizen of foreign country?.....

3. (a) PRINT FULL NAME

Pearl K. Coy

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex..... 5. Color or race..... 6. (a) Single, widowed, married, divorced.....

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

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

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

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

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

19. (a) 3-10-45 (b) D. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March year 1945 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....; that I saw him..... alive on..... 19.....; and that death occurred on the date and hour stated above.

Due to acute pulmonary edema & congestion due to overdose of thyroid extract.

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

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

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) unknown
(b) Date of occurrence 3-8-45
(c) Where did injury occur? H.C. Jackson, Mo.
(d) Did injury occur in or about home, on farm, in industrial place, in public place? unknown.

While at work? no (Specify type of place) (e) Means of injury thyroid extract

23. Signature James C. Walker (M. D. or other) Address Prof. Bldg. Date signed 3-9-45

SUPPLEMENTARY

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

MOTHER FATHER

S-8535