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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 14 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 26747

Registration District No. 27 Primary Registration District No. 5097 Registrar's No. 65

1. PLACE OF DEATH:
(a) County Bates
(b) City or town Shawnee-Twp 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
In this community 20 years (Specify whether years, months or days)

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

3. (a) PRINT FULL NAME Bessie Mae Akins
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 Married
6. (b) Name of husband or wife Homer Akins
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased 5 (Month) — 17 (Day) — 1884 (Year)
8. AGE: Years 61 Months 3 Days 3 If less than one day ____hr. ____min.
9. Birthplace Lovington (City, town, or county) Illinois (State or foreign country)
10. Usual occupation HOUSE Work
11. Industry or business
12. FATHER Name J.C. Welch
13. FATHER Birthplace Dont Know (City, town, or county) Illinois (State or foreign country)
14. MOTHER Maiden name Freeman
15. MOTHER Birthplace Dont Know (City, town, or county) Illinois (State or foreign country)
16. (a) Informant John Wyatt
(b) Address Adrian, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-45 (Month) (Day) (Year)
(c) Place: burial or cremation WHITE OAK Cem.
18. (c) Signature of funeral director Cruath & Son
(b) Address Adrian, Mo
19. (a) 8-22-45 (Date received local registrar) (b) Pauline Crumpton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 20
year 1945 hour 4-pm minute ____ M.
21. I hereby certify that I attended the deceased from June, 1944, to May 1, 1945
that I last saw her alive on May 1, 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cardiac Failure	
Due to Thyroid Toxicosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy WK

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 E. E. Robinson (M. D. or other)
Address Adrian, Mo. Date signed 8-22-45

1340

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 7,
District File Number 8-43-912
Date Filed 9-8-43

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 .....
Ivud V. Creath, Registered Apprentice No. .....,
working under my personal supervision.

Signed Ivud V. Creath

Licensed Embalmer No. 3343

P. O. Address Adrian, 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.