

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9816

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 Registrar's No. 3007

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) OR TOWN St. Louis 2039	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		3. STREET ADDRESS (If rural, give location) 2194 Clifton avenue	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) ETHEL	b. (Middle)	c. (Last) AKERS	MAR. 28		1951
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 4-4-1886	9. AGE (In years last birthday) 64	10. UNDER 1 YEAR Months 11 Days 24
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) McCanda, Ill /	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME John B. Flanagan	13b. MOTHER'S MAIDEN NAME Unknown Samples	14. NAME OF HUSBAND OR WIFE John Akers
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	17. INFORMANT'S SIGNATURE OR NAME John Akers, as above	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 hrs 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Post-operative shock		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cystectomy DUE TO (c) Carcinoma of bladder		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Carcinoma of bladder	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 181X

22. I hereby certify that I attended the deceased from 3-16-51, 19, to 3-28-51, 19, that I last saw the deceased alive on 3-28-51, 19, and that death occurred at 6:10 P.m., from the causes and on the date stated above.

23a. SIGNATURE William W. Coster M.D. (Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 3-29-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 3-31-51	24c. NAME OF CEMETERY OR CREMATORY Lakewood, Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.
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DATE, REC'D BY - LOCAL HEALTH DEPT. J.B. Foster	REGISTRAR'S SIGNATURE J.B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Jay B. Smith, Maplewood, Mo.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *H. Burgess*

Licensed Embalmer No. 4029

P. O. Address Maplewood

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.