THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002663
STATE FILE NUMBER 2 666

FILED FEB 4 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐	c. CITY OR TOWN St. Louis 2069 — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis -Little Rock Hosp. Inc. — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 1365 Belt Ave. — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print)	First: Alex	Middle: -	Last: Akers	4. DATE OF DEATH	Month: Jan. Day: 18 Year: 1959
5. SEX: Male 1	6. COLOR OR RACE: Colored	7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Aug. 17, 1900	9. AGE (In years last birthday): 58	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Platform Laborer	10b. KIND OF BUSINESS OR INDUSTRY: Railroad	11. BIRTHPLACE (City and state or country): Ark.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME: Andrew Akers	14. MOTHER'S MAIDEN NAME: Mariah Johnson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.: 426-26-0898	17. INFORMANT: Mrs Julie E. Akers — Address: 1365 Belt Ave.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brain Tumor

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c) 193.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES X NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 11-24-58, to 1-18-59 and last saw ~~her~~ him alive on 1-18-59
Death occurred at 4:30 Am on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Barton Passamante	22b. ADDRESS: 1755 S. Grand Blvd.	22c. DATE SIGNED: 1/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan. 22, 1959	23c. NAME OF CEMETERY OR CREMATORY: Washington Park	23d. LOCATION (City, town, or county) (State): Berkley, Missouri
24. FUNERAL DIRECTOR ADDRESS: Koonce Funeral Home St. Louis, Mo.	25. DATE RECD. BY LOCAL REG.: JAN 20 '59	26. REGISTRAR'S SIGNATURE: J Earl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Queried: Malignant

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.