

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 28 1960

-60-043276

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11140

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>ST. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		c. CITY OR TOWN <i>UNIVERSITY CITY</i>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>JEWISH HOSPITAL</i>		d. STREET ADDRESS (If outside, give location) <i>7239 TULANE</i>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <i>LLOYD</i> Middle <i>G.</i> Last <i>AKERS</i>			4. DATE OF DEATH Month <i>Nov.</i> Day <i>17</i> Year <i>1960</i>		
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 13 1902</i>	9. AGE (last birthday) <i>58</i>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PRESERVATION SPECIALIST</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>McDONNELL</i>	11. BIRTHPLACE (City and state or country) <i>WEST VIRGINIA</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.-A.</i>	
13a. FATHER'S NAME <i>OLIVER AKERS</i>		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE <i>ESTELLE E. AKERS</i>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES! WAR II</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>ESTELLE E. AKERS</i>	Address <i>7239 TULANE</i>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <i>30 DAYS</i>
IMMEDIATE CAUSE (a) <i>Coronary occlusion</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
DUE TO (c) <i>420.1</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <i>p.m.</i> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <i>1956</i> to <i>1960</i> and last saw him alive on <i>NOV 17, 1960</i> Death occurred at <i>5:30</i> A m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>Robert Q. Smith M.D.</i>	(Degree or title)	22b. ADDRESS <i>4652 Maryland</i>	22c. DATE SIGNED <i>11/18/60</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>NOV. 21 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>NATIONAL CEMETERY</i>	23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>
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24. FUNERAL DIRECTOR <i>Thomas Kute 2906 Genoa</i>	ADDRESS	25. DATE RECD. BY LOCAL REG. <i>NOV 18 1960</i>	26. REGISTRAR'S SIGNATURE <i>Robert Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James P. Hill

Licensed Embalmer No. 434

P. O. Address 2906

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to
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.