

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

PLACE OF DEATH

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

County _____

Township _____

or

Village _____

or

City _____

Registration District No. _____

1003

File No. _____

7129

Primary Registration District No. _____

Registered No. _____

1121

St. _____ 18 Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME

William Ackenhausen

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

DATE OF BIRTH

April 24, 1858
(Month) (Day) (Year)

AGE

51 yrs. mos. ds. IF LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION

(a) Trade, profession, or particular kind of work Store Moulder.

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE

(City or town, State or foreign country) Iron Mountain Mo.

PARENTS

NAME OF FATHER

August Ackenhausen

BIRTHPLACE OF FATHER

Germany

MAIDEN NAME OF MOTHER

Wilhelmina Overmeyer

BIRTHPLACE OF MOTHER

Germany

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Ackenhausen

(ADDRESS)

1213 Clinton St

MAR -4 1910

Filed

1910 Anna S. Inodgers

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

March 3d, 1910
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan. _____, 1910, to March 3, 1910, that I last saw him alive on March 2nd, 1910, and that death occurred, on the date stated above, at 7:00 a.m. The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
23A

Contributory

(SECONDARY)

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) Chas. E. Bauer M. D.
March 3, 1910 (Address) Grand Ave. & E. 10th St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

St. Peters

DATE OF BURIAL

3/6/10 - 1910

UNDERTAKER

A. Horn & Co

ADDRESS

2124 N. 10 St.