ALR FEB 16 1940

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

3498
Do not use this space.

1. PLACE OF DEATH
(a) County Ray 2 Registration District No. 748
(b) Township Richmond 0 Primary Registration District No. 9035
or
(c) City Richmond Mo. (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
Registered No. 264
(e) Length of residence in city or town where death occurred 2.60 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Samuel Tilden Acree

(a) Residence, No. ..... St. [ ]
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Carrie Chaney Acree

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 12-1876

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	64	2	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. .....
10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

FATHER
13. NAME .....
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Geo. Acree

MOTHER
15. MAIDEN NAME Kentucky
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Catherine Jefferson Kerr

17. INFORMANT (ADDRESS) Robert Acree Richmond Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Richmond Mo. DATE Jan 23rd 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) J. B. Brothers Richmond Mo

20. FILED Jan 31 1940 Mabel Jackson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 21 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1940 to Jan 21 1940
Last saw h... alive on Jan 20 1940 Death is said to have occurred on the date stated above, at 7:0... m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Internal Hemorrhage.	
Ruptured Gastric Ulcer	1-20-40

Other contributory causes of importance: 11 Yr
General debility.

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....
(Signed) G. W. Gaines, M. D.
(Address) Richmond, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

50M-9-19-38 I X16605

RECEIVED
District Health Officer No. 8,
District File Number 4/5-120
Date Filed

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.....
Brothers Funeral Home, Registered Apprentice No.....,
working under my personal supervision.

Signed J B Brothers

Licensed Embalmer No. 2001

P. O. Address.....

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, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

3498
Do not use this space.

1. PLACE OF DEATH
(a) County Ray — Registration District No. 744
(b) Township — Primary Registration District No. 2035 — Registered No.
(c) City Richmond (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Samuel Tilden Acree
(a) Residence, No. Richmond Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov 12 1876

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
63 64	2	9	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE ,19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Jan 31 19 40 Mabel Jackson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1 - 21 19 40

22. I HEREBY CERTIFY, That I attended deceased from 19.... to ....., 19.....
I last saw h..... alive on ....., 19..... Death is said to have occurred on the date stated above, at ....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) G. W. Long, M. D.
(Address) Richmond Mo

SUPPLEMENTARY

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.