

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

Do not use this space.

37029

1. PLACE OF DEATH

County Jackson
Township Bellevue
City End. Mo. (No. End. Mo.)

Registration District No. 398
Primary Registration District No. 3019

File No. _____
Registered No. B75
St. _____ Ward _____

2. FULL NAME

Summer S. Stephens

(a) Residence. No. End. Mo. Route 4 St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec 6 - 1901

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
<u>28</u>	<u>11</u>	<u>4</u>		

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Welder.
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Philmore Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Mr Edgar Stephen

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Agnes Strawn

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Mrs Stephens
(Address) # 23 Aldine Court

15. FILED 11-11-29 F. Clark
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 10 1929

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred, on the date stated above, at _____, 11 A.M.,

THE CAUSE OF DEATH WAS AS FOLLOWS:
Fatty Degeneration of Heart

CONTRIBUTORY (SECONDARY) 908
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No. DATE OF 11/11/29
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS _____
(Signed) A. Springinger, M. D.
11-11-29 (Address) Indep. Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Washington DATE OF BURIAL Nov 12 1929

20. UNDERTAKER Rose Henderson ADDRESS 15 of 1st

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.

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