

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.

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

37478
Do not use this space.

1. PLACE OF DEATH
 (a) County Verona Registration District No. 875
 (b) Township Washington Primary Registration District No. 6162 Registered No. 264
 (c) City Marshall (d) Street No. State Hosp #3 Marshall 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. da. (f) How long in U.S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Jesse Lee Summers
 (a) Residence, No. Carl Junction St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 19 - 1892

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
47 7 4

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
 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) Ray County Mo

FATHER
 13. NAME Jes. M. Summers
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

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

17. INFORMANT (ADDRESS) Hosp Records

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Carl Junction DATE Oct 23 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Webb City Ind. Co.
Webb City Mo.

20. FILED Oct 23 1939 Allegre Taylor
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 23 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 25 1939, to Oct 23 1939
 I last saw him alive on 10 - 23 1939. Death is said to have occurred on the date stated above, at 9:00 a.m.
 The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
(Massive without hypertension)
Origin undetermined
 Date of onset 10/23

Other contributory causes of importance:
hypostatic pneumonia
Hydronephrosis left kidney

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

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) J. C. [Signature] M. D.
 (Address) State Hospital #3
Marshall Mo.

RECEIVED

Dis. Health Officer No. 7;
District No. 7-29-15-46
Date Filed 11-6-39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.