

FILED APR 8 1940

Registration District No. 417

Primary Registration District No. 3021

Registrar's No. 39

1. PLACE OF DEATH:

(a) County JASPER
 (b) City or town WEBB CITY
 (c) Name of hospital or institution: 906 W. FIRST ST.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution NO
 In this community 30 YRS.
 years, months or days (Specify whether)

3. (a) PRINT FULL NAME JAMES S. CUMMINS:

8. (b) If veteran, name war NO 8. (c) Social Security No. NO

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced (WIDOWED)

6. (b) Name of husband or wife NEVADA M. (CUMMINS) 6. (c) Age of husband or wife if alive XXX years

7. Birth date of deceased AUG. 28, 1869;
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>6</u>	<u>17</u>	hr. min.

9. Birthplace NEWTON CO MO;
 (City, town, or county) (State or foreign country)

10. Usual occupation RETIRED

11. Industry or business LABORER

MOTHER FATHER
 { 12. Name JESSE CUMMINS
 { 13. Birthplace N. CARLONIA (CAROLINA?)
 { 14. Maiden name CAROLINE WEST
 { 15. Birthplace NO RECORD

16. (a) Informant's own signature Mrs D. L. Lewis
 (b) Address 906 W. 1st ST: WEBB CITY MO

17. (a) BURIAL (b) Date thereof 3-16-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation HORNET:

18. (a) Signature of funeral director HURLBUT UND. CO:
 (b) Address JOPLIN MO:

19. (a) MCH 15. 40 (b) J. L. [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO: (b) County JASPER
 (c) City or town WEBB CITY MO:
 (If outside city or town limits, write "RURAL")
 (d) Street No. 906 W. 1st ST:
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? NO years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MAR. 14, 1940 day
 year hour minute 2-00 P.M.

21. I hereby certify that I attended the deceased from Mch 12 1940 to Mch 14 1940
 that I last saw him alive on Mch 12 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death myocarditis following septicaemia
2 years
 Duration

Due to
 Due to
 Other conditions (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 Of autopsy
 PHYSICIAN
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify)
 (b) Date of occurrence
 (c) Where did injury occur? (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

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 While at work? P. M. Stormont (Specify type of place) (a) Means of injury
 23. Signature Webb City Mo (M. D. or other) Date signed 3/15/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

RECEIVED.

District Health Officer No. 6,

District File Number 440-939

Date Filed: APR 4 1940

939-

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.....

Perry K. Smith, Registered Apprentice No. 939.
working under my personal supervision.

Signed Perry K. Smith

Licensed Embalmer No. 939

P. O. Address Golden M

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.

Registration District No. 417

Primary Registration District No. 3021

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jaeger
(b) City or town Webb City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME James S. Cummins

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 17 If less than one day _____ h. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 14
year 1970 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h. _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction
allowing after infect-
ion of foot. follow my

Due to self-medication of a

Due to corn

Other conditions _____
(Include pregnancy within 3 months of death) 93A

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
Means of injury _____

23. Signature R. M. Stormont (Physician or other) _____

Address Webb City _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

17369 (1940)