

Registration District No. 1077

Primary Registration District No. 6140

Registrar's No. 14

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Rural (Carroll) Tex
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Home
(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 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Texas
(c) City or town Summersville Mo
(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.

3. (a) PRINT FULL NAME William A Summer
8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 23 day Nov.
year 1940 hour 1 AM minute _____ M.
21. I hereby certify that I attended the deceased from 1936
1940, 19 _____, to _____, 19 _____;
that I last saw him alive on Nov. 29, 1940
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced ✓
(b) Name of husband or wife Adelphia Summer 6. (c) Age of husband or wife if alive 40 years
7. Birth date of deceased Aug 20 74
(Month) (Day) (Year)

Immediate cause of death Heart Stroke
Duration _____

8. AGE: Years 74 Months 3 Days 4 If less than one day _____ hr. _____ min.

Due to _____
Due to 45 B
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

9. Birthplace Summersville Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Minister

11. Industry or business _____
MOTHER FATHER { 12. Name Jessie Summer
13. Birthplace Texas
(City, town, or county) (State or foreign country)
14. Maiden name Etha Ordway
15. Birthplace Texas
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Alex Colvine
(b) Address Osborne Mo
17. (a) _____ Date thereof 11-24-40
(Burial, cremation, or removal) (Month) (Day) (Year)

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? 8110

(c) Place: burial or cremation Summersville Mo
18. (a) Signature of funeral director John F. Brown
(b) Address 1111 S. 1st St. Mo
19. (a) Nov. 23 - 1940 J. M. Daniels M.D.
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____
(2) Means of injury _____
23. Signature J. B. McDaniel (M. D. or other) _____
Address Summersville Mo Date signed 11/25/40

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

RECEIVED
District Health Officer No. 5,
District File Number 12701232
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.....

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

Signed John J. Abman
Licensed Embalmer No. 2516
P. O. Address 17th Street, Wm.

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. 1077

Primary Registration District No. 6140

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Carroll
(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 Wm A Summer
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 Married

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

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

8. AGE: Years 74 Months 3 Days 4
If less than one day _____ hr. _____ 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) June 17 1944 (b) Mabel Stepa
(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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: _____ month _____ day
_____ year _____ 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 _____

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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)
(e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

