No. 2
-13-40
17-39
X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 1 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26467

Registration District No. 1103 Primary Registration District No. 6186 Registrar's No.

1. PLACE OF DEATH:
(a) County WASHINGTON
(b) City or town ~~ANTHONIES MILL~~ Johnson
(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 /
In this community 92 Years ✓ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DEASCED:
(a) State Missouri (b) County ~~Franklin~~ Washington 110
(c) City or town Anthonies Mill, (Rural) 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME SUSAN BOONE SUMMERS

3. (b) If veteran, name war No.

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

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

7. Birth date of deceased December 25, 1848 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
92	5	10	hr. min.

9. Birthplace Washington Co. Missouri. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER
12. Name Matlock
13. Birthplace Washington, Co. Mo. (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Henry Summers.
(b) Address Anthonies Mill, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 6, '41 (Month) (Day) (Year)
(c) Place: burial or cremation Metcalf Cemetery.

18. (a) Signature of funeral director
(b) Address Sullivan, Missouri.

19. (a) June 15-41 (Date received local registrar) (b) T. O. Harmon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1941 hour 6 minute P. M.

21. I hereby certify that I attended the deceased from May 27, 1941, to June 5, 1941; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis

Due to

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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

23. Signature [illegible] (M. D. or other)
Address Sullivan Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

S. No. 2B
1—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26467

Registration District No. 1103 Primary Registration District No. 6186 Registrar's No. 2

1. PLACE OF DEATH

(a) County: Washington

(b) City or town: Anthonies Mill Rural
(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 years, months or days)

In this community: 72 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Washington

(c) City or town: Rural Anthonies Mill
(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

3. (a) PRINT FULL NAME: Susan B. Summers

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Wd

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 | Months | Days | If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) June 15-41 (Date received local registrar) (b) J O Harrison (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day year 1941 hour minute M.

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

Immediate cause of death — Duration

Due to Cerebral Thrombosis

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)

(b) 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

SUPPLEMENTARY