

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

FILLED NOV 17 1941

Registration District No. \_\_\_\_\_

Primary Registration District No. 3011

Registrar's No. 105

1. PLACE OF DEATH:

(a) County Co. Day  
 (b) City or town Excelsior Springs Mo  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
707 Summit 1  
(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 about 6 months

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay 24  
 (c) City or town Excelsior Springs 1  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 707 Summit 1  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mary Elizabeth Summers

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

4. Sex female 5. Color or race W 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Marion 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov 8 1878  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>11</u>	<u>14</u>	hr. _____ min. _____

9. Birthplace Monroeville Mo 13  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business \_\_\_\_\_

12. Name Peter Vadnais

13. Birthplace Canada 2  
(City, town, or county) (State or foreign country)

14. Maiden name Wadsworth

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

16. (a) Informant Nellie Thompson

(b) Address Excelsior Springs, Missouri

17. (a) Burial (b) Date thereof 10-24-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill Cemetery Excelsior Springs, Mo.

18. (a) Signature of funeral director Claude Richard

(b) Address Excelsior Springs, Missouri

19. (a) 10/24/41 (b) Ma Rae McEwen  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 22  
 year 1941 hour 2 minute 30 M.

21. I hereby certify that I attended the deceased from August 19 4 to Oct 22 41  
 that I last saw her alive on Oct 22 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death acute uraemic poisoning  
 due to stroke of spleen

Due to uraemic convolution  
Oct 18 - 1941

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

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy no

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) (d) Means of injury \_\_\_\_\_

23. Signature Y. D. Cronan (M. D. or other)  
 Address Excelsior Springs Mo Date signed 10/28/41

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 11-12-41

*[Handwritten notes and signatures, including "10/10/41" and "11/12/41"]*

ADDC

**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 Robert Ray

Licensed Embalmer No. 4152

P. O. Address Excelsior Springs, Mo.

**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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 34641

Registration District No. 198

Primary Registration District No. 3011

Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**

(a) County Clay

(b) City or town Excelsior Springs  
(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 6 mo.

**3. (a) PRINT FULL NAME** Mary E. Summers

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

4. Sex 2 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Nov. 8  
(Month) (Day) (Year)

**8. AGE:** Years 62 Months 11 Days 29 If less than one day 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) \_\_\_\_\_ (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Oct Day 22 Year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death Acute Arteriosclerosis Duration 6 or 7 da.

Asphyxiated

Due to Arteriosclerosis Convulsions 10-15-49

Due to Chronic Nephritis

General arterial sclerosis

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

**PHYSICIAN**

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy none 12/18

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)

(e) Means of injury \_\_\_\_\_

23. Signature G. D. Craven (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

