

FILED DEC 12 1941 9  
Registration District No. \_\_\_\_\_

Primary Registration District No. 4315

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

1. PLACE OF DEATH:

(a) County Macon  
(b) City or town College Mound  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1  
(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. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon  
(c) City or town College Mound  
(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: Cynthia Ann Sumter

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7  
year 1941 hour 9:30 minute 2 M.

21. I hereby certify that I attended the deceased from October 14, 1941 to November 7, 1941;  
that I last saw her alive on November 7, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia following surgery

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 1460

Major findings: Of operations 18

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) accidental fall  
(b) Date of occurrence Oct 14, 1941  
(c) Where did injury occur? College Mound Macon - Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on ~~premises~~, in industrial place, in public place, gas home  
(Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature L. J. Trippeer (M. D. or other) \_\_\_\_\_  
Address College Mound Mo Date signed Nov 7-1941

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

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 Oct 8 1846  
(Month) (Day) (Year)

8. AGE: Years 95 Months - Days 29  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Keeper

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

12. Name John L. Leeper

13. Birthplace College Mound Ky  
(City, town, or county) (State or foreign country)

14. Maiden name Amanda Boyles

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

16. (a) Informant S. V. Sumter

(b) Address College Mound Mo

17. (a) burial (b) Date thereof Nov 9-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation College Mound Mo

18. (a) Signature of funeral director Adrian Skuman  
(b) Address macon mo

19. (a) Nov 15-1941 (b) Mrs R. W. Dowell  
(Date received local registrar) (Registrar's signature)

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

2  
-41  
-39  
K28390

RECEIVED

District Health Officer No. 10

District File Number 12-41-2148

Date Filed DEC 10 1941

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 Albert Skinner

Licensed Embalmer No. 75-1

P. O. Address Macon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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