

No. 2
-1-4-41
5-17-39
I X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41417

State File No. _____

JAN 13 1942 85

Registrar's No. 1233

Registration District No. _____

Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
720 So. 14th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 32 years (Specify whether years, months or days)
In this community 32 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
(c) City or town St. Joseph /
(If outside city or town limits, write "RURAL")
(d) Street No. 720 So. 14th St. 7
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) 6
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29
year 1941 hour 7 minute 55 A.M.
21. I hereby certify that I attended the deceased from Dec 27
1941 to Dec 28 1941
that I last saw alive on Dec 28 1941
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Dec 25/41

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

Major findings: Of operations 83a
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? _____

(Specify type of place) _____
(e) Means of injury _____
23. Signature Robert H. Vandeyan (M. Director)
Address Lawrence St. St. Joseph, Mo. Date signed 12/29/41

3. (a) PRINT FULL NAME William H. Summers

3. (b) If veteran, name war none 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Katherine C. Summers 6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased June 14 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 6 15 hr. min.

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

10. Usual occupation Groceryman

11. Industry or business Merchant,

12. Name James Summers

13. Birthplace Unknown / Virginia
(City, town, or county) (State or foreign country)

14. Maiden name Laura Haskins

15. Birthplace Unknown / Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Wm H. Summers
(b) Address 720 So. 14th Street,

17. (a) Burial (b) Date thereof 12/31/41
(Burial, cremation, or disposal) (Month) (Day) (Year)
(c) Place: burial or cremation Mount Calvary Cem. Atchison, Kansas,

18. (a) Signature of funeral director Neaton B. Gale & Burman (Specify type of place) _____
(b) Address St. Joseph, Mo. (e) Means of injury _____

19. (a) 12-30-1941 (b) H. J. Neathelund
(Date received local registrar) (Registrar's signature) _____

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

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 12-29-4

....., Registered Apprentice No.....

working under my personal supervision.

Signed

W. B. [Signature]

Licensed Embalmer No:

3007

P. O. Address

318 [Signature]

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.