

FILED MAR 17 1942

Registration District No. 283

Primary Registration District No. 4169

Registrar's No.

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Cardwell, Mo  
(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 48- years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County 33  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME

Elizabeth Jane Summitt

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 Widow

6. (b) Name of husband or wife Walter D. Summitt 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Jan 7th 1865  
(Month) (Day) (Year)

8. AGE: Years 77 Months 0 Days 24 If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

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

10. Usual occupation Housewife Retired

11. Industry or business

12. Name Unobtainable - 9  
13. Birthplace Unobtainable -  
(City, town, or county) (State or foreign country)  
14. Maiden name Unobtainable  
15. Birthplace Unobtainable - 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Clarence C. Summitt

(b) Address Cardwell, Mo

17. (a) Burial (b) Date thereof 2/3/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cardwell, Mo

18. (a) Signature of funeral director W. H. Haugard

(b) Address Leitchville, Ark

19. (a) 2-2-42 (b) M. G. Moore  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb, day 1st, year 1942 hour 11 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 25, 1942 to Feb 1, 1942  
that I last saw her alive on Feb 1, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 2 days

Due to Hypertension and Arteriosclerosis DK

Due to Senility

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

Major findings: Of operations 830

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?

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

23. Signature M. C. Glasgow (M. D. or other) D  
Address Cardwell, Mo Date signed 2-3-42

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

MOTHER FATHER

1013

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**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..... *W. H. Howard*

Licensed Embalmer No. *3959*

P. O. Address *Leachville Ark*

**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. 6525  
Registrar's No. ....

Registration District No. 283

Primary Registration District No. 4167

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Cardwell  
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dunklin  
(c) City or town Cardwell  
(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 U.S.A.

3. (a) PRINT FULL NAME Elizabeth J. Summit

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 W

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

7. Birth date of deceased Jan (Month) 7 (Day) \_\_\_\_\_ (Year)

8. AGE: Years 77 Months \_\_\_\_\_ Days 3 If less than one day \_\_\_\_\_ 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director H.H. Howard

(b) Address 2444 Park

19. (a) 2-4-42 (b) M.G. Mouri  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I first saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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

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) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

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

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

MOTHER FATHER

SUPPLEMENTARY

RECEIVED

District Health Office No. 2,

District File Number 642-791

Date Filed JUN 23 1942

JUN 23 1942