

FILED APR 10 1944
Registration District No. 257

Primary Registration District No. 4386

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Oregon
(b) City or town Thayer
(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 Missouri (b) County Oregon
(c) City or town Thayer (Rural)
(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 Judith Elaine Summers

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 Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased. Feb. 15 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Joe Summers

13. Birthplace Thayer Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Nona Whitehead

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

16. (a) Informant Joe Summers

(b) Address Thayer, Mo.

17. (a) Burial (b) Date thereof 1/17/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Norman Cem.

18. (a) Signature of funeral director None

(b) Address 3-10-44
19. (a) 3-10-44 (b) Gae W. Williams
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 16
year 1944 hour 7 minute 00 P. M.

21. I hereby certify that I attended the deceased from 3 or 15
1944 to Feb 16 1944
that I last saw u alive on Feb 16 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Congestive Atelectasis

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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 Gae W. Williams (M. D. or other) MD
Address Thayer, Mo. Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 444236

Date Filed 4-8-44

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 with the above constitutes grounds for revocation of license.)

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