

FILED AUG 13 1946
Registration District No. **336**

Primary Registration District No. **6209**

Registrar's No. **1371804**

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

1. PLACE OF DEATH:

(a) County **Iowa**

(b) City or town **Rural Perry**
(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 **6 mos.** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Iowa**

(c) City or town **Rural Perry**
(If outside city or town limits, write "RURAL")

(d) Street No. **112 N. of Houston**
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HULDA MELVINA SUMMERS**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **13** year **1946** hour **10** minute **30 A.** M.

21. I hereby certify that I attended the deceased from **May 11** 19 **46** to **July 12** 19 **46**
that I last saw h. **as** alive on **July 12** 19 **46**
and that death occurred on the date and hour stated above.

4. **Female** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Luther** 6. (c) Age of husband or wife if alive **77** years

7. Birth date of deceased **Mar. 17 1869**
(Month) (Day) (Year)

Immediate cause of death **Broncho pneumonia** Duration **12 hrs**

Due to **multiple cerebral thromboses** **8-5 yrs**

Due to **arterio sclerosis - senility** **Indeterminate**

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

8. AGE: Years **77** Months **3** Days **26** If less than one day _____ hr. _____ min.

9. Birthplace **Montank** (City, town, or county) **Mo.** (State or foreign country)

10. Usual occupation **House wife**

Major findings:
Of operations _____

Of autopsy **107**

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name **Bob Hubber**

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

14. Maiden name **Mary Ruth**

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

16. (a) Informant **Mrs. Effie Willie**

(b) Address **Houston, Mo.**

17. (a) **Burial** (b) Date thereof **7/16/46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Houston**

18. (a) Signature of funeral director **Gaylord V. Elliott**

(b) Address **Houston, Mo.**

19. (a) **7-29-1946** (b) **Myrtle Craig**
(Date received local registrar) (Registrar's signature)

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 **R. T. Harsh** (M. D. or other) **97.29**

Address **Houston Mo** Date signed **7-10-46**

RECEIVED

District Health Officer No. 5,

District File Number 846463

Date Filed 8-9-46

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 Frank E. Wood
Licensed Embalmer No. 4026
P. O. Address Houston, Tex

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.