

FILED SEP 11 1947

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 6296

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Rural Nelder  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3 1/2 miles N. West Burfordville  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community Entire Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Cape Gir 16  
(c) City or town Rural (If outside city or town limits, write "RURAL") 3  
(d) Street No. near Burfordville Mo. (rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 1  
year 1947 hour 3 minute 15 P.M.  
21. I hereby certify that I attended the deceased from Aug  
1947, to Sept 1, 1947  
that I last saw h. alive on Aug 28, 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration 1 week  
Due to Hypertension 10 yrs

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy 63A  
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 0  
23. Signature T. S. Ruff (M. D. or other) MD  
Address Jackson mo Date signed 9/4/47

3. (a) PRINT FULL NAME EMMA C. 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 married

6. (b) Name of husband or wife C. C. Summers 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased Jan 30 - 1877  
(Month) (Day) (Year)

8. AGE: Years 70 Months 7 Days 1 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Jackson Mo. D  
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

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

12. Name Jesse Criddle  
13. Birthplace Jackson Mo. D  
(City, town, or county) (State or foreign country)

14. Maiden name Housekeeper  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant David Summers  
(b) Address Chaffee Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof Sept 3 - 1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director J. Miller  
(b) Address \_\_\_\_\_

19. (a) 9-5-47 (Date received local registrar) (b) T. S. Ruff (Registrar's signature) 112

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

600

MOTHER, FATHER

RECEIVED

District Health Officer No. 4

District File Number 947-1169

Date Filed 9-10-47

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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 *Gene C. Crawford*

Licensed Embalmer No. 4937

P. O. Address *Jackson, Miss*

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.