S. No. 2
M—8-43
5-17-39
P I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 10 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30048

Registration District No. 3 24

Primary Registration District No. 6092

Registrar's No. 169

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Grand Pass, Rural (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 65 yrs years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97

(c) City or town Grand Pass Rural 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME WILLIAM ISAAC SUMMERS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced married 1

6. (b) Name of husband or wife Mahalia Young Summers

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Oct (Month) 13 (Day) 1872 (Year)

8. AGE: Years 74 Months 10 Days 0 If less than one day hr. min.

9. Birthplace Macon Co (City, town, or county) Mo (State or foreign country)

10. Usual occupation unemployed

11. Industry or business

FATHER
12. Name Wm Summers
13. Birthplace — (City, town, or county) Mo 0 (State or foreign country)

MOTHER
14. Maiden name Sarah Bingaman
15. Birthplace — (City, town, or county) Ill. 1 (State or foreign country)

16. (a) Informant Mrs M.S. Holloway
(b) Address Marshall Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Grand Pass Mo

18. (a) Signature of funeral director Harry Hershberger
(b) Address Marshall Mo

19. (a) Aug 15-1947 (Date received local registrar) (b) Sidney T. Gray (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13 year 1947 hour 9 minute 20 P M.

21. I hereby certify that I attended the deceased from AUG 13th, 1947, to AUG 13, 1947 that I last saw him alive on AUG 13, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death CEREBRAL HEMORRHAGE	1 DAY
Due to	
Due to	
Other conditions HYPERTENSION AND ARTERIO SCLEROSIS GENERAL (Include pregnancy within 3 months of death)	6 yrs

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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0

23. Signature Geo A Kelling (M. D. or other)
Address Waverly Mo Date signed 8-15-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7-9-47

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall Mo

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.