

FILED AUG 20 1949

STANDARD CERTIFICATE OF DEATH

26429  
State File No. \_\_\_\_\_  
Registrar's No. 83

BIRTH NO. _____		REG. DIST. NO. <u>71</u>		PRIMARY REG. DIST. NO. <u>3012</u>		Registrar's No. <u>83</u>		
1. PLACE OF DEATH a. COUNTY <u>Clay</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Kansas</u> b. COUNTY <u>Wyandotte</u>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Excelsior Springs, Mo.</u>		c. LENGTH OF STAY (In this place) <u>6 mo. 27 da</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		14		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Veterans Administration Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>2109 Merriam Blvd.</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Fred</u> b. (Middle) <u>A</u> c. (Last) <u>Summers</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 8, 1949</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>April 10, 1894</u>		9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Garage</u>		11. BIRTHPLACE (State or foreign country) <u>Princeton, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Charles Summers</u>			13b. MOTHER'S MAIDEN NAME <u>Belle Tuttle</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>496097815</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Records, Veterans Administration Hospital, Excelsior Springs, Missouri</u> ADDRESS _____				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculosis, pulmonary, reinfection type,</u> ANTECEDENT CAUSES <u>far advanced, active, severe symptoms</u> DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS <u>Asthma, chronic, bronchial</u> <u>Emphysema, pulmonary</u> Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>  <u>002X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT (Specify) _____ SUICIDE _____ HOMICIDE _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from <u>Dec. 12, 1948</u> , to <u>July 8, 1949</u> , that I last saw the deceased alive on <u>July 8, 1949</u> , and that death occurred at <u>3:05 P. M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE <u>S. C. STROFF</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>Excelsior Springs, Missouri</u>		23c. DATE SIGNED <u>7-8-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>July 8, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Maple Grove Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Trenton, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>7/8/49</u>		REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hope Funeral Home, Excelsior Springs, Mo.</u> ADDRESS _____				

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

RECEIVED AUG 9

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 8-18-79

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....

Student Embalmer

Signed

*Chas Virgil Hope*

Licensed Embalmer No. 3950

P. O. Address

*Electric Springs,*

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.