

FILED AUG 29 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26441

25

REG. DIST. NO. 72 PRIMARY REG. DIST. NO. 6289 Registrar's No. 90

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Gallatin (Rural)</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural Gallatin</u>	
c. LENGTH OF STAY (in this place) <u>10 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>R.F.D. # 11</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>R.F.D. # 11</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Alva</u> b. (Middle) <u>Walton</u> c. (Last) <u>Summers</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 15 49</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 23, 1880</u>
9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u> Hours <u>10</u> Min. <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>Mt. Vernon, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Groc. Store</u>	14. NAME OF HUSBAND OR WIFE <u>Otta Summers</u>	
13a. FATHER'S NAME <u>James Clarence</u>	13b. MOTHER'S MAIDEN NAME <u>Tennessee Warren</u>	14. NAME OF HUSBAND OR WIFE <u>Otta Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>500-22-1390</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Victor Fletcher</u> ADDRESS <u>GL 3231</u>	
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>Coronary Heart Disease</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Chronic cellulitis of leg</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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>Aug 6, 1949</u> , to <u>Aug 15, 1949</u> , that I last saw the deceased alive on <u>Aug 15, 1949</u> , and that death occurred at <u>7:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>L. Barbara Fowler M.D.</u> (Degree or title)		23b. ADDRESS <u>2025 Swift - N.H.C. no</u>	
23c. DATE SIGNED <u>8/17/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>17 Aug 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon, Ill.</u>	24d. LOCATION (City, town, or county) (State) <u>Mt. Vernon Ill.</u>
DATE REC'D BY LOCAL REG <u>Aug 17 - 49</u>	REGISTRAR'S SIGNATURE <u>Beulah Kitchener</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Maston</u> ADDRESS <u>N.H.C.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED AUG 22

District Health Officer No. 8.

District File Number.....

Date Filed 8-27-49

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 *Harold L. Posson*

Licensed Embalmer No. 3605

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.