

FILED DEC. 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40830

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>128</u>		PRIMARY REG. DIST. NO. <u>2000</u>		Registrar's No. <u>1087</u>	
1. PLACE OF DEATH a. COUNTY <u>GREENE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>HOWELL</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD,</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>MOUNTAIN VIEW, MO.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>O'REILLY VA HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>ROUTE # 1</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>PAUL</u>		b. (Middle)		c. (Last) <u>SUMMERS</u>	
4. DATE OF DEATH <u>12:15PM Dec 8/49</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>Feb. 16, 1921</u>		9. AGE (In years last birthday) <u>28</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Arroll, Missouri</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13a. FATHER'S NAME <u>John Summers</u>		13b. MOTHER'S MAIDEN NAME <u>Bessie House</u>		14. NAME OF HUSBAND OR WIFE <u>Phyllis Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>VA HOSPITAL RECORDS, SPRINGFIELD, MISSOURI</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>Nephritis, tuberculous, bilateral, severe</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>DU TO (b) Tuberculosis, pulmonary, moderately advanced primary, left apex.</u> DU TO (c) <u>Disseminated hematogenous tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>Dec. 5</u> , 19 <u>49</u> , to <u>Dec. 8</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>49</u> , and that death occurred at <u>12:15p m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>P. L. EISELE, M.D. SERVICES</u>				23b. ADDRESS <u>O'REILLY VA HOSPITAL SPRINGFIELD, MISSOURI</u>		23c. DATE SIGNED <u>12-8-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>December 10, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>unknown</u>		24d. LOCATION (City, town, or county) (State) <u>Mt. View, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>12-10-49</u>		REGISTRAR'S SIGNATURE <u>W. B. Haudley</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bernard Schaefer Home Springfield, Mo.</u>			

(Licensed/Embalmer's Statement on Reverse Side)

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

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.

Signed Gene Hunter

Signed.....
Student Embalmer

Licensed Embalmer No. 4739

P. O. Address Springfield, 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.