

No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4520

BIRTH NO. _____ REG. DIST. NO. 114 PRIMARY REG. DIST. NO. 486 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN		c. LENGTH OF STAY (In this place) 9 DAYS	
d. FULL NAME OF HOSPITAL OR INSTITUTION NORTHSIDE HOSPITAL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN 0361	
		d. STREET ADDRESS (If rural, give location) 0	

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) FRANK c. (Last) SUMMERS			4. DATE OF DEATH (Month) (Day) (Year) Feb 27-1952		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MARCH 20, 1859	9. AGE (In years last birthday) 92	IF UNDER 1 YEAR Months 11 Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) WASHINGTON COUNTY MO		12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME WILLIAM SUMMERS	13b. MOTHER'S MAIDEN NAME LUCINDIA PINSON	14. NAME OF HUSBAND OR WIFE MARY HARMON SUMMERS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Rush Summers ADDRESS Sullivan, Mo.

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 1/2 9 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) fracture of right femur - fall - ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Abuse from above DUE TO (b) General debility DUE TO (c) _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION E9030 036 20	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE accident	21b. PLACE OF INJURY (e.g., in or about home, factory, street, office bldg., etc.) Miller house	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Sullivan rural, Franklin MO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Feb 19-1952 9:30 a.m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Fell in room

22. I hereby certify that I attended the deceased from **2-19-1952**, to **2-27-1952**, that I last saw the deceased alive on **2-27-1952**, and that death occurred at **7:30** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Embalmers O.M.A.	23b. ADDRESS	23c. DATE SIGNED 2-28-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 3/1/52	24c. NAME OF CEMETERY OR CREMATORY KIMBERLIN	24d. LOCATION (City, town, or county) (State) ANTONIES MIL MO
DATE REC'D BY LOCAL REG. 2-28-52	REGISTRAR'S SIGNATURE Embalmers O.M.A.	25. FUNERAL DIRECTOR'S SIGNATURE Wheaton ADDRESS Sullivan, Mo.	

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

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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Edna W. Fallow

Licensed Embalmer No. 1 2394

P. O. Address Nallawan 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.