

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18483**
DIVISION OF HEALTH
Registrar's No. **0171238**

FILED JUN 15 1953

BIRTH NO. _____ REG. DIST. NO. **107** PRIMARY REG. DIST. NO. **5582**

490
1

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

1. PLACE OF DEATH a. COUNTY Jasper		2. USUAL RESIDENCE (Where deceased lived; If institution residence before admission) a. STATE Missouri b. COUNTY Jasper	
b. CITY OR TOWN Diamond Rt. #1 c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Diamond Rt. #1 d. STREET ADDRESS Jackson Twn.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jackson Twn.		(If rural, give location) 0490	

3. NAME OF DECEASED (Type or Print) a. (First) Louis	b. (Middle)	c. (Last) Summers	4. DATE OF DEATH (Month) (Day) (Year) 5-29-1953
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-16-1900	9. AGE (in years last birthday) 52	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 MIN. Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (His kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (City and State or Foreign Country) Galena, Kansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Joseph Summers	13b. MOTHER'S MAIDEN NAME Emma Myers	14. NAME OF HUSBAND OR WIFE Lillie Stress Johnson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.	16. SOCIAL SECURITY NO. 496050526	17. INFORMANT'S SIGNATURE OR NAME Mrs. Lillie Summers	ADDRESS Diamond, Mo.
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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 over 10 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary tuberculosis		
	II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 002X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **20 Mar '52**, 19___, to **29 May '53**, 19___, that I last saw the deceased alive on **12 May '53**, 19___, and that death occurred at **9:01 A** m., from the causes and on the date stated above.

23a. SIGNATURE J. E. Burk M. D.	(Degree or title)	23b. ADDRESS Carthage Missouri	23c. DATE SIGNED 1 June '53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-1-1953	24c. NAME OF CEMETERY OR CREMATORY Stonie Point Cem.	24d. LOCATION (City, town, or county) (State) Diamond Rt. #1, Mo.
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DATE REC'D BY LOCAL REG. 6-1-53	REGISTRAR'S SIGNATURE L. B. Clinton M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Ulmer Funeral Home	ADDRESS Carthage Mo.
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RECEIVED 6-13-53
Jasper County Health Office

53-6-509

County File Number _____

Date Filed 6-13-53

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

William B. Cantrell

Licensed Embalmer No. 4820

P. O. Address *Carters 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.