

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 9 1954

State File No. _____

No. 300
10-48

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 361

1. PLACE OF DEATH
a. COUNTY Marion
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HANNIBAL
c. LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LEYERING HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Missouri b. COUNTY Monroe
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL ROUTE-3 HUNNEWELL
d. STREET ADDRESS (If rural, give location) SOUTH OF HUNNEWELL

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE b. (Middle) FRANKLIN c. (Last) SUMMERS
4. DATE OF DEATH (Month) (Day) (Year) 11-23-1954

5. SEX MALE 6. COLOR OR RACE COLORED 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 8. DATE OF BIRTH 2-22-1891 9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months 9 Days 1 IF UNDER 12 HRS. Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME CHARLIE SUMMERS 13b. MOTHER'S MAIDEN NAME MARY FRANKIS DAVIS 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. None 17. INFORMANT'S SIGNATURE OR NAME Leo Summers ADDRESS HUNNEWELL MO

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fat embolism MEDICAL CERTIFICATION
INTERVAL BETWEEN ONSET AND DEATH 24 hrs
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) fracture of hip 48 hrs.
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR _____

22. I hereby certify that I attended the deceased from July, 1953, to 11-23, 1954, that I last saw the deceased alive on 11-22, 1954, and that death occurred at 11:02 m., from the causes and on the date stated above.

23a. SIGNATURE T. G. Doerchler (Degree or title) _____ 23b. ADDRESS Shelburne, Mo 23c. DATE SIGNED 11-29-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 11-27-54 24c. NAME OF CEMETERY OR CREMATORY NORTH FORK CEM. 24d. LOCATION (City, town, or county) (State) NORTH FORK MO

DATE REC'D BY LOCAL REG. 12-1-54 REGISTRAR'S SIGNATURE Dr. E. M. Lucke 189-0 FURNERAL DIRECTOR'S SIGNATURE Harold Turner ADDRESS Monroe City

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

DEC 7 1964

RECEIVED

MARION CO. HEALTH DEPT.

DATE FILED

DEC 7 1964

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 Turner

Licensed Embalmer No. *3720*

P. O. Address *Monroe City*

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.