

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1955

State File No. **31551**  
Registrar's No. **7762**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7762</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>21 2603 Olive St Victory Hotel</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>EDGAR</b>		b. (Middle) <b>FRANKLIN</b>		c. (Last) <b>SUMMERS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT 3, 1955</b>	
5. SEX <input checked="" type="checkbox"/> male	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>divorced</b>	8. DATE OF BIRTH <b>Feb. 6 1889</b>		9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>5</b> Days <b>25</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Cape Girardeau Mo.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Wm. A. Summers</b>			13b. MOTHER'S MAIDEN NAME <b>America Hopper</b>			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>493 10 2607</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. James Casey 5844 Etzel Ave.</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bleeding from esophageal varices</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cirrhosis of liver</b> DUE TO (c) <b>chronic alcoholism</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>581.1</b>				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) m. _____		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 <b>9-2-55</b> , 19____, to <b>SEPT. 3, 1955</b> , that I last saw the deceased alive on <b>9-3-55</b> , 19____, and that death occurred at <b>8:00 P.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Martin H. Austin M.D.</b>				23b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		23c. DATE SIGNED <b>9-5-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 6 1955</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cem.</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>	
DATE REC'D BY LOCAL REG. <b>SEP 6 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. JUNEAN - DIRECTOR'S SIGNATURE ADDRESS <b>Cullinane Pro. 3320 N. Kingshighway</b>			

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

*m J.B.* (Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Francis J. Wylan*.....

Licensed Embalmer No. *451*.....

P. O. Address *St. Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.