

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27897
STATE FILE NUMBER

FILED AUG 30 1956

53463-56 Registration District No. 290 Primary Registration District No. 5985 Registrar's No. 114

Health, Welfare, Public Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Pulaski			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pulaski		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Fort Leonard Wood, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY. OR TOWN Fort Leonard Wood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION US Army Hospital		Length of stay in 1b 6 hrs. 20 min	d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sue Ann Cummins <i>First Middle Last</i>			4. DATE OF DEATH August 22, 1956 <i>Month Day Year</i>		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 August 1956	9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours 6 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY x	11. BIRTHPLACE (City and state or country) Fort Leonard Wood, Mo.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Vernon Porter Cummins			14. MOTHER'S MAIDEN NAME Alice Marie Greene		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. None.	17. INFORMANT Robert T. Burbeck Address US Army Hospital ROBERT T. BURBECK, CWO, USA, Ft. Leonard Wood, Mo.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Birth					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) _____					
DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased ^{ON} 22 August 1956 , to _____ and last saw her ^{ALIVE} 22 August 56 Death occurred at 10:20 _____ m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>William R. Raloff</i> (Degree or title)			22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri.		22c. DATE SIGNED 22 Aug 56
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/24/56	23c. NAME OF CEMETERY OR CREMATORY Crocker Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Crocker, Mo.	
24. FUNERAL HOME Hedges Funeral Home		25. DATE RECD. BY LOCAL REG. 8-24-56		26. REGISTRAR'S SIGNATURE <i>Gene G. Anderson</i>	

RECEIVED 8-25-56
Putaski County Health Officer
114
File Number
Date Filed 8-24-56

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..

Not Embalmed

Student.....
Signature of Student Embalmer

Signed *Carroll J. Cross*

Licensed Embalmer No. *48*

P. O. Address *Waynesville*

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.