

FILED JUL 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25396

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 257

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Levering Hospital</u>		Length of stay in lb <u>7/7/57</u>	d. STREET ADDRESS <u>1200 Vermont</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>GEORGE ANTHONY SUMMERS</u>			4. DATE OF DEATH <u>July 11, 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1870</u>	9. AGE (In years last birthday) <u>87</u>	IF UNDER 1 YEAR Month <u>4</u> Days <u>10</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Button Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (City and state or country) <u>Ladonia Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>J. J. Summers</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Trabue</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Lester Summers, Hannibal Missouri</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Conjunctive heart failure</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4341</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u>
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 <u>Hannibal, Marion, Mo.</u>		20g. COUNTY <u>Marion</u>
21. I attended the deceased from <u>7/6/57</u> to <u>7/11/57</u> and last saw her/him alive on <u>7/11/57</u> Death occurred at <u>4:15 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>J. W. Watterschief M.D.</u>		(Degree or title)	22b. ADDRESS <u>Hannibal, Mo.</u>		22c. DATE SIGNED <u>7/12/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7/13/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>		
24. FUNERAL DIRECTOR <u>W. C. Crawford Smith</u>		ADDRESS <u>Hannibal Missouri</u>	25. DATE RECD. BY LOCAL REG. <u>7-16-57</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luckey by Mc Fisher</u>	

Health, Welfare, Public Service

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Doctor, coroner, etc. must use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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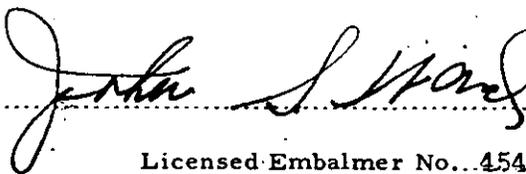
(Licensed Embalmer's Statement on Reverse Side)

RECEIVED JUL 26 1957
MARION CO. HEALTH DEPT
DATE FILED JUL 26 1957

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.....


Licensed Embalmer No. 454

P. O. Address Hannibal, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.