

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32732

STATE FILE NUMBER

FILED SEP 16 1957

Registration District No. 226 Primary Registration District No. 4337 Registrar's No. 29

300
1-57

1. PLACE OF DEATH a. COUNTY Monroe		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Missouri b. COUNTY Monroe	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Madison		c. CITY OR TOWN Madison	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION XXXXXXXXXX		d. STREET ADDRESS (If outside, give location) XXXXXXXXXX	
3. NAME OF DECEASED (Type or print) First Middle Last Alva A Summers		4. DATE OF DEATH Month Day Year 9 / 7 / 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/1879
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming	11. BIRTHPLACE (City and state or country) Monroe Co. Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming		10b. KIND OF BUSINESS OR INDUSTRY retired farmer	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME I N Summers		13b. MOTHER'S MAIDEN NAME Mary Williams	14. NAME OF HUSBAND OR WIFE Pollie E Gillispie
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. none	17. INFORMANT John Summers Address Madison, Mo R R
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO (b) Cerebral Hemorrhage DUE TO (c) arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 days unknown
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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 from <u>July 15-57</u> to <u>Sept. 7-57</u> and last saw <u>alive</u> on <u>Sept. 7-57</u> Death occurred at <u>2:30 P. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) J. C. Kelley DO		22b. ADDRESS 2 Nobely, Mo	
		22c. DATE SIGNED 9-7-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE Sept 9/57	
23c. NAME OF CEMETERY OR CREMATORY Middle Grove Cemetery		23d. LOCATION (City, town, or county) (State) Middle Grove Mo	
24. FUNERAL DIRECTOR Tress A. Kempf		25. DATE RECD. BY LOCAL REG. Sept 10, 1957	
		26. REGISTRAR'S SIGNATURE Elsie Robertson	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related. From query

FEB 9 1961

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 *Mrs. Fred A. Kump*

Licensed Embalmer No. *2582*

P. O. Address *Madison*

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.