

FILED OCT 28 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **36592**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **187** PRIMARY REG. DIST. NO. **3040** Registrar's No. **245-1**

1. PLACE OF DEATH a. COUNTY <b>Linn</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>Linn</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>Chillicothe</b>		c. LENGTH OF STAY (In this place) <b>Life</b>	c. CITY OR TOWN <b>Chillicothe</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Chillicothe Hospital</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) <b>#24 Cowgill</b>		<b>05-9-57</b>	

3. NAME OF DECEASED a. (First) <b>Margaret</b> b. (Middle) <b>Frances</b> c. (Last) <b>Summers</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>10-14-57</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>	8. DATE OF BIRTH <b>10-30-70</b>		9. AGE (In years last birthday) <b>86</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Linn MO</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>

13a. FATHER'S NAME <b>George H. Powell</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Stanley</b>		14. NAME OF HUSBAND (If deceased) <b>Arthur Summers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Albert L. McLaughlin</b> ADDRESS <b>Chillicothe MO</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <b>arteriosclerosis</b>			
		DUE TO (c) <b>4221</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Anemia - severe unknown</b>					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" 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)		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 **Dec 1955**, to **10-14**, 19**57**, that I last saw the deceased alive on **10-14**, 19**57**, and that death occurred at **8:10 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Joseph F. Gale</b>		23b. ADDRESS <b>Chillicothe MO</b>		23c. DATE SIGNED <b>10-15-57</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-17-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Edgewood</b>		24d. LOCATION (City, town, or county) (State) <b>Chillicothe MO</b>	
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DATE REC'D BY LOCAL REG <b>10/15/57</b>		REGISTRAR'S SIGNATURE <b>Frances B. Hill</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>E. Buckett</b> ADDRESS <b>Chillicothe MO</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

171-0

**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 *E. Beckwith*.....

Licensed Embalmer No. *329*

P. O. Address *Chulley*

**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.