

Health & Welfare  
Public  
Service

DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-028386  
STATE FILE NUMBER

FILED AUG 22 1958

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 472

300  
1-57  
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1. PLACE OF DEATH a. COUNTY <b>Butler</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dunklin</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Poplar Bluff</b>		c. CITY OR TOWN <b>Malden</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Poplar Bluff Hosp.</b>		d. STREET ADDRESS (If outside, give location)	
Length of stay in 1b <b>10 da.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>Fred</b> Last <b>Summers</b>			4. DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>1958</b>		
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5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1886</b>	9. AGE (In years last birthday) <b>71</b>	10. UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (retired)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and state or country) <b>Acorn Ridge, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Charles W. Summers</b>	13b. MOTHER'S MAIDEN NAME <b>Betty Hollis</b>	14. NAME OF HUSBAND OR WIFE <b>Sam Summers Dexter, Mo.</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>yes 1911 to 1914</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Sam Summers Dexter, Mo.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic myocarditis</b>		<b>5 yrs.</b>
	DUE TO (c) <b>Arteriosclerosis</b>		<b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>4321</b>		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.)
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20c. TIME OF INJURY Hour <b>0</b> a.m. <b>0</b> 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
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21. I attended the deceased from <b>July 10-58</b> , to <b>July 21-58</b> and last saw him alive on <b>July 21, 1958</b> Death occurred at _____ on the date stated above; and to the best of my knowledge, from the causes stated.	22a. SIGNATURE (Degree or title) <b>Cyril A. Post M.D. Poplar Bluff, Mo.</b>	22b. ADDRESS	22c. DATE SIGNED <b>7-24-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>7-23-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hollis cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>Bloomfield, Mo.</b>
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24. FUNERAL DIRECTOR <b>Watkins &amp; Sons</b>	ADDRESS <b>Dexter, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>7/26/58</b>	26. REGISTRAR'S SIGNATURE <b>R. Minette</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. Any unknown elements in Part II. No symptoms will be listed.

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RECEIVED

AUG 19 1958

BUTLER CO. HEALTH CENTER

FILE No. \_\_\_\_\_

AUG 22 1958

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 Mark Withers  
Licensed Embalmer No. 4717  
P. O. Address Seale, Md

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.