

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-013123

STATE FILE NUMBER

FILED APR 21 1959

Registration District No. 141 Primary Registration District No. 3035 Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <u>Haskell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Worth</u>	
b. CITY OR TOWN <u>West Plains</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>West Plains</u> 0461 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>1132 Grace</u> Length of stay in lb <u>74rd</u>		d. STREET ADDRESS <u>1132 Grace</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cornelia L. Summers</u>			4. DATE OF DEATH Month Day Year <u>4-5-1959</u>
5. SEX <u>2</u> 1	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Greenbush Mo</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Joe Lennell</u>	13b. MOTHER'S MAIDEN NAME <u>Macey Turley</u>
14. NAME OF HUSBAND OR WIFE <u>Mrs. Helen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>962X</u>
17. INFORMANT <u>Mrs. Helen</u> Address <u>West Plains Mo</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>Hemiplegia (cerebral hem left)</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic glomerulonephritis</u> <u>2 years</u> DUE TO (c) <u>fracture l. leg at neck femur</u> <u>6 yrs</u> 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.) <u>47</u>			
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>West Plains</u> COUNTY <u>Worth</u> STATE		21. I attended the deceased from <u>Nov. 21, 52</u> to <u>4-5-59</u> and last saw her <sup>her</sup> alive on <u>4-3-59</u> Death occurred at <u>home</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Virgil D. Dailey D.O.</u>		22b. ADDRESS <u>West Plains Mo.</u>	
22c. DATE SIGNED <u>4-8-59</u>		23a. BURIAL CREMATION, REMOVAL (Specify)	
23b. DATE <u>4-6-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East Crest</u>	
23d. LOCATION (City, town, or county) - (State) <u>West Plains Mo</u>		24. FUNERAL DIRECTOR <u>Robertson West Plains, Mo</u> ADDRESS	
25. DATE RECD. BY LOCAL REG. <u>4-17-59</u>		26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

**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 *[Handwritten Signature]* .....

Licensed Embalmer No. *3430* .....  
P. O. Address *Leeds, Pa* .....

**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.**