

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016419
STATE FILE NUMBER

FILED APR 27 1959

Registration District No. 323 Primary Registration District No. 6089 Registrar's No. 13

300
1-57

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LAFAYETTE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELMWOOD TOWNSHIP</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>CORDER</u> <u>0540</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1/2 MI. S.W. SHACKLEFORD MO</u>		Length of stay in 1b <u>5 DAYS</u>	d. STREET ADDRESS <u>3 1/2 MI. S.E.</u> (If outside, give location)
		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>EMMET</u> Middle <u>SUMMERS</u> Last	4. DATE OF DEATH Month <u>APRIL</u> Day <u>12</u> Year <u>1959</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11 1882</u>	9. AGE (In years last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>NEAR CORDER MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>MICHAEL W. SUMMERS</u>	13b. MOTHER'S MAIDEN NAME <u>SUSAN HAGERTY</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>500-10-7999</u>	17. INFORMANT <u>ROBT. M. EDWARDS</u> Address <u>SHACKLEFORD MISSOURI</u>
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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) _____ DUE TO (b) <u>Carcinoma of pancreas</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 MO</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.)
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20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <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>159</u>	COUNTY _____ STATE _____
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21. I attended the deceased from <u>1937</u> to <u>April 12, 1959</u> and last saw him alive on <u>April 12, 1959</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Paul Lowell M.D.</u>	22b. ADDRESS <u>711 W 46th St</u>	22c. DATE SIGNED <u>4/18/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>APRIL 15 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>HIGGINSVILLE MISSOURI</u>
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24. FUNERAL DIRECTOR <u>A. H. HAGER FUNERAL HOME</u> <u>by J. J. Walker</u>	ADDRESS <u>HIGGINSVILLE MO</u>	25. DATE RECD. BY LOCAL REG. <u>April 23, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mary Mosley</u>
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(Licensed Embalmer Statement on Reverse Side)

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, ~~only~~, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Wm. L. Thurman*

Licensed Embalmer No. *4563*
P. O. Address *Richmond, M.D.*

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.