

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039064**

**FILED VS DEC 7 1959**

042

1000

1184

STATE FILE NUMBER

RECORDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Gentry</b>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>22 days</b>		c. CITY OR TOWN <b>Albany</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hosp.</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <b>ARCH</b> Middle <b>C.</b> Last <b>SUMMA</b>				<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>21,</b> Year <b>1959</b>					
<b>5. SEX</b> <b>male</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 6, 1886</b>	<b>9. AGE (last birthday)</b> <b>73</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>farm</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Albany, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>		
<b>13a. FATHER'S NAME</b> <b>William Summa</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Harriett Hopkins</b>			<b>14. NAME OF HUSBAND OR WIFE</b> <b>Sarah Francis Summa</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>unknown</b>		<b>17. INFORMANT</b> Address <b>Mrs. Sarah F. Summa, Albany, Mo.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Heart Disease &amp; Failure</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 Weeks</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Chronic Pulmonary Emphysema</b>								<b>6 yrs.</b>	
DUE TO (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Chronic Bronchitis</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____							
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____		STATE _____	
<b>21. I attended the deceased from</b> <b>10-30-59</b> , to <b>11-21-59</b> and last saw <sup>her</sup> him alive on <b>11-21-59</b> Death occurred at <b>11:55p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
<b>22a. SIGNATURE</b> (Degree or title) <b>H.C. Senne M.D.</b>				<b>22b. ADDRESS</b> <b>207 Pcs Bldg, St. Joseph Mo</b>			<b>22c. DATE SIGNED</b> <b>11-23-59</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>removal</b>		<b>23b. DATE</b> <b>11/22/1959</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Albany Mo.</b>				
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>Walter Bowman St. Joseph, Mo.</b>			<b>25. DATE RECD. BY LOCAL REG.</b> <b>Nov. 30, 1959</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Mr. Clark Stoddell</b>				

DOCUMENT

MEDICAL CERTIFICATION  
H.C. Senne, M.D.

BY AFFIDAVIT OF

the license  
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**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 William Spalding

Licensed Embalmer No. 4538

P. O. Address St Joseph

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.