

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-026372

FILED VS. JUL 21 1960 107

Primary Registration District No. 3019

Registrar's No. 143

STATE FILE NUMBER

|  |   |   |   |   |  |  |  |
|--|---|---|---|---|--|--|--|
| 1. PLACE OF DEATH  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) |  |  |  |
| a. COUNTY<br><b>Dunklin</b>  |   | b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>Kennett</b>   |   | a. STATE<br><b>Mo.</b>  |  | b. COUNTY<br><b>New Madrid</b>   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br><b>Dunklin Co. Memorial</b>   |   | Length of stay in 1b<br><b>1 Day</b>  |   | c. CITY OR TOWN<br><b>Gideon,</b>   |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
|  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location)   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>           |  |
| 3. NAME OF DECEASED (Type or print)  |   |   |   | 4. DATE OF DEATH  |  |  |  |
| First<br><b>MINNIE</b>   |   | Middle<br><b>LEE</b>  |   | Last<br><b>SUMMERS</b>  |  | Month Day Year<br><b>6-18-1960</b>   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9-22-1884</b>        | 9. AGE (last birthday)<br><b>75</b>   | IF UNDER 1 YEAR<br>Months Days   | IF UNDER 24 HR<br>Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>  |   | 11. BIRTHPLACE (City and state or country)<br><b>Swifton, Arkansas</b>                |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME<br><b>George Vanwinkle</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Unknown</b> |   | 14. NAME OF HUSBAND OR WIFE<br><b>John Summers</b>   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT Address<br><b>Henshel Bell Gideon, Mo.</b>                              |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| IMMEDIATE CAUSE (a)<br><b>Cerebral Hemorrhage</b>  |   |   |   |   |  | <b>2 Hours</b>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br><b>Hypertension</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)  |   |   |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>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.)  |   |   |  |  |  |
| 20c. TIME OF INJURY<br>Hour a.m. p.m.<br>Month, Day, Year  |   |   |   |   |  |  |  |
| 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   |  |
|  |   | <b>6/18/60</b>  |   | <b>6/18/60</b>  |  | <b>6/18/60</b>   |  |
| 21. I attended the deceased from <b>6/18/60</b> to <b>6/18/60</b> and last saw her him alive on <b>6/18/60</b> .<br>Death occurred at <b>7:00 a</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |   |   |  |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>Ernest Summers, MD</b>  |   |   |   | 22b. ADDRESS<br><b>Kennett, Mo</b>  |  | 22c. DATE SIGNED<br><b>7-11-60</b>   |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>6-20-1960</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Malden Park Cem.</b>                         |  | 23d. LOCATION (City, town, or county) (State)<br><b>Malden, Mo</b>                   |  |
| 24. FUNERAL DIRECTOR<br><b>Lloyd Russell</b>   |   |   | ADDRESS<br><b>Piggott, Ark.</b>             |   | 25. DATE RECD. BY LOCAL REG.<br><b>July 12-1960</b>  |  | 26. REGISTRAR'S SIGNATURE<br><b>Earl Sturman</b> |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Lloyd Russee*

Licensed Embalmer No. 509-

P. O. Address Peggett,

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.