

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-027774

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Registration District No. _____ Primary Registration District No. _____ Registrar's No. 43 STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Ozark</u>	b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Bakersfield</u>	a. STATE <u>Mo.</u>	b. COUNTY <u>Ozark</u>
Length of stay in 1b <u>29 yrs</u>		c. CITY OR TOWN <u>Bakersfield</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <input checked="" type="checkbox"/>		d. STREET ADDRESS <input checked="" type="checkbox"/> (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>David Lawrence Summers</u>			4. DATE OF DEATH <u>4/24-60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-94</u>	9. AGE (last birthday) <u>65</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) <u>Hazard Co. Ark</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>Joe L. Summers</u>	13b. MOTHER'S MARDEN NAME <u>Mary E. Farmer</u>	14. NAME OF HUSBAND OR WIFE <u>Rachel Summers</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>452</u>	17. INFORMANT <u>Rachel Summers, Bakersfield Mo</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>Myocardial Insufficiency</u>	<u>one hr</u>
DUE TO (b)	<u>Coronary Occlusion</u>	<u>6 hrs</u>
DUE TO (c)	<u>Arterio-sclerotic Heart Disease</u>	<u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cardiac Hypertrophy</u>		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

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"/>	21. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY	Hour _____ a.m. _____ p.m.	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 _____

21. I attended the deceased from Nov 19, 1959 to Nov 28, 1959 and last saw him alive on Dec 7, 1959
 Death occurred at 11:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Murray D. Hutchins, M.D.</u>	22b. ADDRESS <u>913 W. Main West Plains, Mo.</u>	22c. DATE SIGNED <u>5-6-1960</u>
23a. BURIAL, CREMATION, REPOSAL (Specify) <u>10</u>	23b. DATE <u>4-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pauline</u>
23d. LOCATION (City, town, or county) <u>Pauline Ark</u>	(State) _____	
24. FUNERAL DIRECTOR <u>Bakersfield Mo</u>	ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>7-30-60</u>
		26. REGISTRAR'S SIGNATURE <u>Thava Mahan</u>

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

A. S. Roberts

Licensed Embalmer No. 343

P. O. Address West Park

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.