

FEDERAL BUREAU OF INVESTIGATION  
 DEPARTMENT OF JUSTICE  
 DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040595

FILED VS NOV 2 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3035

1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		c. CITY OR TOWN <u>Saint Louis</u>	
Length of stay in 1b <u>13 days</u>		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>Normandy Osteopathic Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>9027 Goodfellow</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>May</u> Last <u>Summer</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>12-14-1898</u>	9. AGE (last birthday) <u>61</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>

13a. FATHER'S NAME <u>George Walbridge</u>		13b. MOTHER'S MAIDEN NAME <u>Ella Devaney</u>		14. NAME OF HUSBAND OR WIFE <u>Ralph L. Summer</u>	
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>488-01-3368</u>		17. INFORMANT Address <u>Ralph Summer - 9027 Goodfellow Blvd</u>	

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Failure</u> DUE TO (b) <u>Carcinomas</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause (as f.)			
PART III. 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 SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour <u>11:32pm</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 JAN, 1940 to Oct 17, 1960 and last saw her alive on OCT. 17, 1960  
 Death occurred at 11:32pm on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. H. Hoffmann, M.D.</u> (Degree or title)	22b. ADDRESS <u>8700 Riverview</u>	22c. DATE SIGNED <u>10/18/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>Oct. 20, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>
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24. FUNERAL DIRECTOR ADDRESS <u>BUCHHOLZ MORT., - 5967 W. Florissant Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>10-18-60</u>	26. REGISTRAR'S SIGNATURE <u>John E. Murphy M.D.</u>
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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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. James

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.