

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-035014

STATE FILE NUMBER **4724**

Registration District No. **149** Primary Registration District No. **1002** Registrar's No. **4724**

FILED SEP 28 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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205/15

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF **Frank Paul Laurensana** MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Johnson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>		Length of stay in lb <b>15 yrs.</b>	c. CITY OR TOWN <b>Warrensburg</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>K. C. Convelescent Home</b>		d. STREET ADDRESS (If outside, give location) <b>339 E. Market St.</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MATTIE T SUMMERS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>13</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1871</b>
9. AGE (last birthday) <b>91</b>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Knobnoster, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>Francis Hull</b>	
13b. MOTHER'S MAIDEN NAME <b>Louisa H enrietta Robinson</b>		14. NAME OF HUSBAND OR WIFE <b>Benjamin Franklin Summers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. B. F. Summers</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>	
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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 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 <b>2-10-50</b> to <b>9-13-62</b> and last saw her/him alive on <b>9-13-62</b> Death occurred at <b>2:45 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE <b>Frank Paul Laurensana MD</b> (Degree or title)		22b. ADDRESS <b>428 South White Ave</b>	22c. DATE SIGNED <b>9-13-62</b> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-13-62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Knob Noster Cem.</b>	23d. LOCATION (City, town, or county) <b>Knob Noster, Mo.</b>
24. FUNERAL DIRECTOR <b>Melody-McGilley-Eylar</b> ADDRESS <b>Woodland</b>		25. DATE RECD. BY LOCAL REG. <b>9-14-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>

USE BLACK INK OR TYPEWRITER RIBBON

Mr. Laurence  
428 S. White  
Pe 1-3319

Will call and let us  
know when & where  
he can sign cert.

**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 James Wain

Licensed Embalmer No. 4650

P. O. Address K.C. Mo.

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.