

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025047

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 200 Primary Registration District No. 3041 Registrar's No. 86

STATE FILE NUMBER

FILED JUL 2 1963	
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>MACON</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MACON</u> Length of stay in 1b <u>1 DAY</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Samaritan Hospital</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>	<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> b. COUNTY <u>MACON</u></p> <p>c. CITY OR TOWN <u>MACON</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>307 E. Douglas</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) <u>JENNIE OPAL Summers</u></p> <p>5. SEX <u>Female</u></p> <p>6. COLOR OR RACE <u>White</u></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u></p> <p>13a. FATHER'S NAME <u>James Preston Mason</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No.</u>)</p>	<p>4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1963</u></p> <p>7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>2-3-1886</u></p> <p>9. AGE (last birthday) <u>77</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>-</u></p> <p>11. BIRTHPLACE (City and state or country) <u>Callao, Missouri</u></p> <p>12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u></p> <p>13b. MOTHER'S MAIDEN NAME <u>Alice Wright</u></p> <p>14. NAME OF HUSBAND OR WIFE <u>Deceased</u></p> <p>16. SOCIAL SECURITY NO. <u>[Redacted]</u></p> <p>17. INFORMANT Address <u>Mrs Nadine Groves ST Louis Mo</u></p>
<p>18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Cerebral Vascular occlusion</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension chronic</u> <u>years</u></p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p> <p>20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____</p> <p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____</p>	<p>21. I attended the deceased from <u>1957</u> to <u>15 June 63</u> and last saw her ^{her} alive on <u>15 June 63</u></p> <p>Death occurred at <u>12:10 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>
<p>22a. SIGNATURE (Degree or title) <u>Donald E. Eggleston MD</u></p> <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p> <p>23b. DATE <u>June 17, 1963</u></p> <p>23c. NAME OF CEMETERY OR CREMATORY <u>Callao, Cemetery</u></p> <p>23d. LOCATION (City, town, or county) <u>Callao, Missouri</u></p> <p>24. FUNERAL DIRECTOR ADDRESS <u>Lester Hutton MACON, Mo.</u></p>	<p>22b. ADDRESS <u>MACON, Missouri</u></p> <p>22c. DATE SIGNED <u>20 June 63</u> (State)</p> <p>25. DATE RECD. BY LOCAL REG. <u>6-27-63</u></p> <p>26. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

JUL 3 1963

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 Billy H. Binder

Licensed Embalmer No. 5034

P. O. Address Macon

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.