

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Buchanan  
Township Center  
or  
Village \_\_\_\_\_  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 80 File No. 5440  
Primary Registration District No. 5119 Registered No. # 6

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Carl J. Sumner

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE single MARRIED WIDOWED OR DIVORCED (Write the word)  
DATE OF BIRTH January 14, 1916 (Month) (Day) (Year)  
AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 14 ds. IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work at home  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE (City or town, State or foreign country) Fayette Mo

PARENTS  
NAME OF FATHER James J. Sumner  
BIRTHPLACE OF FATHER (City or town, State or foreign country) Alta  
MAIDEN NAME OF MOTHER Lizzie Waldron  
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Texas

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) James Sumner  
(ADDRESS) Fayette Mo

Filed 2/4/16 1916 R. F. Howell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH January 31, 1916 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from January 25, 1916, to January 31, 1916, that I last saw him alive on January 25, 1916, and that death occurred, on the date stated above, at 7.9 m. The CAUSE OF DEATH\* was as follows:

Acute catarrhal enterocolitis  
119.33  
(Duration) 104 mos. 6 ds.

Contributory (SECONDARY) \_\_\_\_\_ (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
(Signed) W. S. Bell M. D.  
Feb 1 1916 (Address) Quincy Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.  
LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)  
At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
Where was disease contracted if not at place of death? \_\_\_\_\_  
Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL State Cemetery DATE OF BURIAL 2/3/16 1916  
UNDERTAKER Blumenbach ADDRESS St Joseph Mo

# Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health  
Association]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc. of

..... (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicaemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, (or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

1 PLACE OF DEATH  
 Course Buchanan  
 Township Center  
 or  
 Village  
 or  
 City

Registration District No. 80  
 Primary Registration District No. 5119

File No. 15440  
 Registered No. 6

2 FULL NAME

Carl J. Summers

St.:  
 Ward: X

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 SINGLE  MARRIED  WIDOWED  OR DIVORCED   
 (Write the word)

6 DATE OF BIRTH  
 (Month) (Day) 1 (Year)

7 AGE  
 If LESS than 1 day.....hrs. or.....min.?  
 .....mos.

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
 (City or town, State or foreign country)

10 NAME OF FATHER James J. Summers

11 BIRTHPLACE OF FATHER Farrell  
 (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
 (Month) (Day) (Year)  
Jan 31 1916

17 I HEREBY CERTIFY, that I attended deceased from ..... 191..... to..... 191..... that I last saw him..... alive..... 191..... and that death occurred, on the date stated above, at..... m. The CAUSE OF DEATH\* was as follows:  
 ..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY  
 (Secondary) ..... (Duration)..... yrs..... mos..... ds.  
 (Signed)..... M. D.  
 ..... 191..... (Address).....

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
 At place of death..... yrs..... ds. In the State..... yrs..... mos..... ds.  
 Where was disease contracted if not at place of death?  
 Former or usual residence.....

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL  
 ..... 191.....

20 UNDERTAKER ADDRESS  
R. F. Dowell

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) J. D. Summers  
 (Address) Farrell Mo.

15 Filed 7/30 1916 R. F. Dowell  
 Registrar

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SUPPLEMENTARY INFORMATION SUPPLIED

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