

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

Do not use this space.

18125

JUL 27 1927

1. PLACE OF DEATH

County Howell
Township Spineycreek
City Howell

Registration District No. 384
Primary Registration District No. 55A

File No. 56
Registered No. _____
St. _____ Ward _____

2. FULL NAME

John Thomas Summers

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

male

4. COLOR OR RACE

white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

widower

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

April 9th 1869

7. AGE

YEARS	MONTHS	DAYS	IF LESS than 1 day, ____ hrs. or ____ min.
<u>60</u>	<u>2</u>	<u>16</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Ga.

10. NAME OF FATHER

Wm Summers

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) N Carolina

12. MAIDEN NAME OF MOTHER

Mattie Burgess

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) N Carolina

14.

INFORMANT Wm Summers
(Address) West Plains, Mo

15.

FILED 6-30-27 1927 O.P.A. Neuenich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

6-25-27

17.

I HEREBY CERTIFY, That I attended deceased from May 22, 1927, to June 25, 1927, that I last saw him alive on June 28, 1927, and that death occurred, on the date stated above, at 5:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

81- Aneurysm of Ascending Aorta
311
38
96 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

37- Syphilis
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? X-Ray

(Signed) Eleanor Bohrer, M. D.

6-27, 1927 (Address) West Plains, Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Coke Run

DATE OF BURIAL

6-26-1927

20. UNDERTAKER

W. Harland and Co. West Plains, Mo

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.

THIS IS A PERMANENT RECORD

