

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

Do not use this space.

21142

6 1027

PLACE OF DEATH
County Frank Registration District No. 318
Towship Springfield Primary Registration District No. 2001
City Springfield (No. 1350 N. Flower Ave) Registered No. 422
St. _____ Ward _____
2. FULL NAME Augusta Summers
(a) Residence No. 1350 N. Flower Ave St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married
6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 27 1872
7. AGE YEARS 33 MONTHS 3 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-4-1927
17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to 7-4-1927, that I last saw him alive on 7-4-1927, and that death occurred, on the date stated above, at 4:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer of Stomach
4 1/2 yrs (duration) 2 yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. _____ mos. _____ ds.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
10. NAME OF FATHER Paul Linder
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
12. MAIDEN NAME OF MOTHER Augusta Linder
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) Germany
14. INFORMANT Charles Summers
(Address) 1350 N. Flower Ave
15. Filed 7/6 27 19____ O. C. Horst REGISTRAR

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
7/1 (Signed) J. J. Tillery M. D.
1350 N. Flower Ave (Address) Springfield 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 Highland DATE OF BURIAL 7-6-27
20. UNDERTAKER W. H. Harter Mark

N. E.—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.

