

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City *St. Louis Mo.* (No. *3300 Missouri Ave.*)

Registration District No. *791*  
Primary Registration District No. *1003*

File No. *26254*  
Registered No. *746-I*  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

*Peggy L. Summers*  
(a) Residence. No. *3300 Missouri* St., *24* Ward.

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. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write the word*) *Single*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Oct. 5 - 1928*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, .....hrs. or .....min.
	<i>0</i>	<i>9</i>	<i>13</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *None*  
(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) *Murphysboro Ill.*

10. NAME OF FATHER *Harry Summers*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Murphysboro Ill.*

12. MAIDEN NAME OF MOTHER *Thelma Fieldy*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Murphysboro Ill.*

14. INFORMANT *Mary Summers* (Address) *3300 Missouri Ave.*

15. FILED 19 *May 21 1929* REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 18 - 1929*

17. I HEREBY CERTIFY, That I attended deceased from *July 13<sup>th</sup>*, 1929, to *July 18<sup>th</sup>*, 1929, that I last saw h. e. l. alive on *July 18<sup>th</sup>*, 1929, and that death occurred, on the date stated above, at *7:10* m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*Acute Enteritis*  
*1195* (duration) ..... yrs. mos. *5* ds.

CONTRIBUTORY (SECONDARY) *1130* (duration) ..... yrs. mos. ds.

**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? *Clinical course*

(Signed) *P. M. Rohman*, M. D.

*7/19* 1929 (Address) *1454 Cass Ave.*

\*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 *Murphysboro Ill.* DATE OF BURIAL *7-19-1929*

20. UNDERTAKER *Ziegenhein Bros. 2623 Cherokee* ADDRESS

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

