MAR 28 1930

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

Do not use this space.

2366

1. PLACE OF DEATH
County Ray
Township Grape Grove
City ..... (No. ..... St. ..... Ward)

Registration District No. 914
Primary Registration District No. 6235

File No. .....
Registered No. # 1

2. FULL NAME Mary Martha 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: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan - 3 - 1848

7. AGE: YEARS 89 | MONTHS | DAYS 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer): Living with
(c) Name of employer: Son

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Virginia

PARENTS
10. NAME OF FATHER: John Frank
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY):
12. MAIDEN NAME OF MOTHER: Dont No.
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Dont No.

14. INFORMANT (Address): Joe Summers Hardin Mo

15. FILED Feb 12, 1930 W. E. Gant REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Jan 28 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to ....., 19.... that I last saw her alive on Jan 25, 1930, and that death occurred, on the date stated above, at 4:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Diabetes Mellitus
59
9317
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Myocarditis
..... (duration) ..... yrs. ..... mos. ..... ds.

57

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
(Signed) Carl H Reed, M. D.
Jan 28, 1930 (Address) Hardin

*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: Wakenda Cem
DATE OF BURIAL: Jan-29 1930

20. UNDERTAKER: Jno W. Knipschild
ADDRESS: Hardin Mo

...tem of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ...
...ATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importa...

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Ray Registration District No. 914 File No.

Township Grape Grove Primary Registration District No. 6235 Registered No. 1

City (No. St. Ward)

2. FULL NAME Mary Martha 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 F

4. COLOR OR RACE W

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

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY) don't know

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT
(Address)

15. FILED Feb 12, 1930 W E Gant
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 28 1930

17. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 that I last saw h alive on , 19 , 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.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) , M. D

, 19 (Address)

*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 | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

...ould state ...ly supplied. AGE should be stated EXACTLY. PHYSICIANS should state ...em of informati... be properly classified. Exact statement of OCCUPATION is very im... TH in plain t...

...RARS SHALL NOT RE... ...OR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED F... LA...

S-2364