

REC'D FEB 20 1939

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

1226

Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Kaw Primary Registration District No. 1002 Registered No. 239
 (c) City Kansas City, Mo. (d) Street No. Research Hospital, K.C. Mo. St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Viola Summers,

(a) Residence, No. 3231 Roberts, Avenue, K.C. Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 22nd, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
64 6 24

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri13. NAME Thomas Miller14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri15. MAIDEN NAME Wink Heisel16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) No Record17. INFORMANT Robert Summers, (ADDRESS) 3231 Roberts Avenue, K.C. Mo.18. BURIAL, CREMATION, OR REMOVAL at Salem Cem. at place Exp. Spr. Mo. DATE Jan. 20, 193919. FUNERAL DIRECTOR (NAME) Mrs. C.L. Forster (ADDRESS) 918 Brooklyn Avenue, K.C. Mo.20. FILED Jan 19, 1939 M. M. Grove Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 16th, 193822. I HEREBY CERTIFY, That I attended deceased from Armed to _____, 19____

I last saw h. _____ alive on _____, 19____ Death is said to have occurred on the date stated above, at 6:35 P.M.

The principal cause of death and related causes of importance were as follows:

Automobile trauma
Fracture of thoracic spine
Fracture of ribs and sternum
210 mg.
hi

Date of onset

Other contributory causes of importance: hi

Name of operation _____ Date of _____
 What test confirmed diagnosis _____ Was there an autopsy yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide Date of injury 11/2/38Where did injury occur? Clay Co. Mo. (Specify city or town, county, and State)Specify whether injury occurred in industry, in home, or in public place. HighwayManner of injury Collision of truck and motor car

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? If so, specify _____

(Signed) J. F. Holt _____, M. D.(Address) _____

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.