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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
792
MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 1008 Primary Registration District No. _____ Registrar's No. 9323

1. PLACE OF DEATH: 1401 N. 8th Street
(a) County. St. Louis
(b) City or town St. Louis, Mo.
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____
years, months or days

8. (a) PRINT FULL NAME William Summers
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Celia Summers 6. (c) Age of husband or wife if alive 51 years
7. Birth date of deceased August 11 1870
(Month) (Day) (Year)

8. AGE: Years 69 Months 2 Days 16 If less than one day _____ hr. _____ min.

9. Birthplace Jackson Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Unknown

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name Unknown (City, town, or county) (State or foreign country)

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Celia Summers

(b) Address 1401 N. 8th Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-39 (Month) (Day) (Year)

(c) Place: burial or cremation Cape Girardeau, Mo.

18. (a) Signature of funeral director Mary Wade

(b) Address 4202 Finney Ave.

19. (a) OCT 31 1939 (Date received local registration) (b) J. F. Budick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1401 N. 8th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 27th year 1939 hour 2 minute 15 A.M.

21. I hereby certify that I attended the deceased from Oct 26, 1939 to Oct 27, 1939 that I last saw him alive on Oct 27, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
cerebral hemorrhage
Due to _____
Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. F. Budick (M. D. or other) _____

Address 823 N. 16th St Date signed 10/29/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

Rev. 5-17-39 1 X19511

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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.....

.....
working under my personal supervision.

..... Registered Apprentice No.

Signed.....

J. J. Watson
..... Licensed Embalmer No. *2698*

..... P. O. Address *2767 Choate*

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.