

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

1. PLACE OF DEATH

(a) County Saline  
(b) City or town Summit Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location) 2  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 30 yrs years, months or days

8. (a) PRINT FULL NAME Albert Hearn 1950

3. (b) If veteran, name war No 8. (c) Social Security No. 472-14-1743

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Laura May Hearn 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased June 20, 1880  
(Month) (Day) (Year)

8. AGE: Years 59 Months 11 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Knopville Ill.  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Funeral Work

12. Name Spencer M. Hearn

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

14. Maiden name Josephine Loring

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

16. (a) Informant Chas. W. Hearn

(b) Address Summit Springs Mo

17. (a) Burial (b) Date thereat 6-16-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director R. C. Carter

(b) Address Summit Springs Mo

19. (a) 6/4/40 (b) R. M. Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline  
(c) City or town Summit Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 4  
year 40 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from 4  
- 4, 1940, to 6-4-40, 1940

that I last saw him alive on 6-4-40, 1940,  
and that death occurred on the date and hour stated above.

Immediate cause of death Retro bulbar  
Myeloma & metastasis  
to anterior cervical ganglia 2 mo

Due to Retro bulbar

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 57

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? \_\_\_\_\_

980 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Chas. R. Pearson (M. D. or other) 1 M 40

Address Summit Springs Mo Date signed 6-4-40

RECEIVED  
District Health Officer No. 8  
District File Number  
Date Filed 6-6-40

**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 *R. C. Carter*

Licensed Embalmer No. *3513*

P. O. Address *St. Louis, Mo.*

**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.**