

Registration District No. 398

Primary Registration District No. 5564

Registrar's No. 177

1. PLACE OF DEATH:

(a) County Jackson, Blm. Co.
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution 10812 East 19th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Independence
(If outside city or town limits, write "RURAL")
(d) Street No. 10812 East 19th.
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

In this community _____

3. (a) PRINT FULL NAME

Percy Summers

3. (b) If veteran, name war. none

3. (c) Social Security No. none

4. Sex male

5. Color white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Bertrude Summers

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased May 13 1885

(Month) (Day) (Year)

8. AGE:

Years 55 Months 1 Days 23 If less than one day _____ hr. _____ min.

9. Birthplace

Paradise Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation

Electrician

11. Industry or business

MOTHER FATHER
12. Name Robert Summers
13. Birthplace unknown
14. Maiden name Sarah Douglas
15. Birthplace unknown

16. (a) Informant

Bertrude Summers

(b) Address

10812 East 19th St

17. (a)

Burial (b) Date thereon July 9-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation

Forest Hill Cem

18. (a) Signature of funeral director

George Cannon

(b) Address

Independence MO

19. (a)

July 9-40 (b) H. L. Cook
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH

Month July day 6
year 1940 hour 110 minute 35P M.

21. I hereby certify that I attended the deceased from

1938, 19 to July 6, 1940
that I last saw him alive on July 5, 1940
and that death occurred on the date and hour stated above

Immediate cause of death

myocarditis

Duration

2 yrs

Due to

Due to

Other conditions

Paraplegia
(Include pregnancy within 3 months of death)

Major findings:

Of operation for 18 yrs or more.

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? _____

23. Signature

George Cannon (M. D. or other) 1
Address 11037 Wimmer Rd Date signed 7-9-40
Indep.

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

92c

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

Ralph E. Miller

Licensed Embalmer No. *4124*

P. O. Address *Independence, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **25-345**
Registrar's No. **177**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **398**

Primary Registration District No. **5354**

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

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Blue Springs**
(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 _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Percy Summers

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **m**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____

(Month)

(Day)

(Year)

8. AGE:

Years **55** Months **1** Days **23**

If less than one day _____ min.

9. Birthplace _____

(City, town, or county)

(State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____

(City, town, or county)

(State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county)

(State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 **July** day **6**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial** Duration _____

Due to _____ **g1w**

Due to _____

Other conditions **Paraplegia for**
(Include pregnancy within 3 months of death)
18 years & more

Major findings: **of spinal drip**

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) (c) Means of injury _____

23. Signature **Rep. M. Pals** (M. D. or other) _____

Address **Independence** _____

SUPPLEMENTARY

