

Registration District No. 417Priority Registration District No. 5021Registrar's No. 120

## 1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME Frank Summons

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Widowed 6. (c) Age of husband or wife if alive \_\_\_\_\_ years7. Birth date of deceased Dec 31 1873  
(Month) (Day) (Year)8. AGE: Years 67 Months 11 Days 10 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace Webb City Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation Tram Conductor11. Industry or business 912. Name Tom W. Summons13. Birthplace Unknown  
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth Bowers15. Birthplace Webb City Missouri  
(City, town, or county) (State or foreign country)16. (a) Informant Webb City Undertaking Co(b) Address Webb City17. (a) Burial (b) Date thereof Nov 13 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Carterville Cem18. (a) Signature of funeral director Webb City Und Co(b) Address Webb City Mo19. (a) NOV 11 40 (b) J. H. Ditcher  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper  
 (c) City or town Webb City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 601 East Tracy  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 10  
year 1940 hour 1040 minute P M.21. I hereby certify that I attended the deceased from 11-2, 1940, to Nov 10, 1940  
that I last saw him alive on 11-10, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Pneumonia  
(Pneumonia)  
 Due to cold & influenza  
 Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

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? 377While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury 90023. Signature J. H. Ditcher (M. D. or other 900)Address Webb City Mo Date signed 11-11-40

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

109

**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 myself,

....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Wayton M. Johnston

Licensed Embalmer No. 3,922

P. O. Address Wells City, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38934

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 417

Primary Registration District No. 3020

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Jasper  
(b) City or town West city  
(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)  
(d) Length of stay: In hospital or institution (Specify whether  
In this community years, months or days)

3. (a) PRINT FULL NAME Frank Simmons

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 wid  
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 Months Days If less than one day  
67 11 10 hr 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 (City, town, or county) (State or foreign country)

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

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (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 Nov day 10  
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 and that death occurred on the date and hour stated above.

Immediate cause of death (Pneumonia)

(Pulmonary)

Due to Cold & Silicosis

Due to Toxin

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 108

Of autopsy

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?

(Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTAL COPY

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

S-38934 1940