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

Do not use this space.

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1. PLACE OF DEATH

County Scotland — Registration District No. 810 — File No.

Township Union — Primary Registration District No. 6056 — Registered No. 6

City ..... (No. ..... St. ..... Ward)

2. FULL NAME Alma Summers (SUMMERS)

(a) Residence. No. Scotland Co Mo. Rural Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 2 - 1862

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	79		12	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Scotland Co.
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Leper Yeager

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) West Virginia

12. MAIDEN NAME OF MOTHER Sophia Boswell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) West Virginia

14. INFORMANT W. N. Summers
(Address) Centrif Fwd

15. FILED 2-18-1941 E. E. Parrish REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 14 1941

17. I HEREBY CERTIFY, That I attended deceased from June, 1936, to Feb. 14, 1941, that I last saw her alive on June 6, 1940, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Carcinoma of breast.
Metastic -

..... (duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Physical Ex.
(Signed) E. E. Gilfillan M. D
, 19 (Address) Memphis, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mapel Grove	Feb 16 1941
20. UNDERTAKER	**ADDRESS**
E. G. Wellborn	Centrif Fwd

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.

RECEIVED
District Health Officer No. 10
District File Number 2-41-459
Date Filed FEB 21 1941