

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41440

Registrar's No. 284

FILED DEC 20 1943

Registration District No. 7

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Community Nursing Home 4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo s & 6 da s
(Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town Stahl
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Osby Summers

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Male 5. Color or Race White 6. (a) Single, widowed, married, divorced, Married
6. (b) Name of husband or wife Alta Elsea Summers 6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Jan. 28 1879
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 9 8 hr. _____ min.

9. Birthplace Excello Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer & Miner

11. Industry or business _____

MOTHER FATHER { 12. Name Andrew Jackson Summers
13. Birthplace Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Amv Elizabeth Brown
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Alta Elsea Summers
(b) Address Stahl, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/43
(Month) (Day) (Year)
(c) Place: burial or cremation Novinger, Missouri

18. (a) Signature of funeral director J. E. Riley
(b) Address Kirkville, Missouri

19. (a) 11/12/43 (Date received local registrar) (b) Wm. J. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 6
year 1943 hour 8:00 minute P. M.

21. I hereby certify that I attended the deceased from October Twenty eighth 1943 to November 6 1943; that I last saw him alive on November 6, 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Chronic poisoning

Due to Gout & Pyelitis

Due to enlarged prostate
Caecum & prostate

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations 518

Of autopsy No 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? _____

While at work? _____ (Specify type of place) (e) Means of injury 2

23. Signature A. P. Schultz (M.D. or other) Dr
Address 238 E. Benton Kirkville Mo Date signed 11/9/43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 12-43-2037

Date Filed DEC 18 1943

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 *L. E. Riley*.....

Licensed Embalmer No. 4181.....

P. O. Address *Rockville, Md*.....

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.