

FILED JAN 4 1942

STANDARD CERTIFICATE OF DEATH

41732

State File No. ....

Registrar's No. ....

Registration District No. 42

Primary Registration District No. 1000

1297

1. PLACE OF DEATH

(a) County Buchanan  
(b) City or town St. Joseph Mo  
(c) Name of hospital or institution State Hosp. N 2 2  
(d) Length of stay: In hospital or institution 3 years 3 mths 2 days  
In this community 3 years 3 mths 2 days

3. (a) PRINT FULL NAME

Obie SUMMERS

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male

5. Color of skin white

6. (a) Single ~~divorced~~ married

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

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased

Sept (Month)

10 (Day)

1869 (Year)

8. AGE:

Years 74

Months 2

Days 14

If less than one day

9. Birthplace

Mo

10. Usual occupation

Farmer & Blacksmith

MOTHER FATHER

11. Industry or business

12. Name

Robert Summers

13. Birthplace

Mo Ia. 1

14. Maiden name

Blay Co. Mo. 0

15. Birthplace

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

16. (a) Informant

Mrs. Mary Summers

(b) Address

Smithville Mo

17. (a) Burial

Nov. 26, 43

(c) Place: burial or cremation

Blay Co. Mo

18. (a) Signature of funeral director

W. McCollins

(b) Address

Smithville Mo.

19. (a) 11-26-43

(Date received local registrar) (b) Roe Higog (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clay  
(c) City or town Smithville  
(d) Street No.  
(e) Citizen of foreign country? no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 24 year 1943 hour 1 minute 50 P.M.

21. I hereby certify that I attended the deceased from Nov 21, 1943, to Nov 24, 1943, that I last saw him alive on Nov 24, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral Hemorrhage & Uremia

Due to: Senile Psychosis

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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature: O. E. ... (M. D. or other) Address: State Hospital ... Date signed: 12-4-43

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**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.....

*S. A. McQuinn*

Licensed Embalmer No. ....

*2303*

P. O. Address.....

*Smithville, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1797

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution State Hosp # 2  
(If not in hospital or institution, write street number and 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 Obe 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 \_\_\_\_\_

7. Birth date of deceased Sept 15 1884  
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days \_\_\_\_\_ (less than one day) \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 24 Year 1943 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

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

Immediate cause of death Cerebral Hemorrhage  
& Aremia acuta

Due to Senile Psychosis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
830!

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-41732