DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 24 1944

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 17911

Registration District No. 101 | Primary Registration District No. 5406 | Registrar's No. 34

1. PLACE OF DEATH:
(a) County: Douglas
(b) City or town: Ava Lincoln
(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 years, months or days): 75 yr
In this community: 75 yr

2. USUAL RESIDENCE OF DECEASED: 34
(a) State: Missouri (b) County: Douglas
(c) City or town: Ava rural
(If outside city or town limits, write "RURAL")
(d) Street No.: Route 3 – Lincoln Twp
(If rural, give location)
(e) If foreign born, how long in U. S. A.? / years.

3. (a) PRINT FULL NAME: Samuel Edward Kummur
3. (b) If veteran, name war: No
3. (c) Social Security No.: No
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Emmie McAnesie Kummur
6. (c) Age of husband or wife if alive: 62 years
7. Birth date of deceased: June 4 1868 (Month) (Day) (Year)
8. AGE: Years 75 | Months 10 | Days 26 | If less than one day ___ hr. ___ min.
9. Birthplace: ------ (City, town, or county) Ohio / (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
MOTHER FATHER
12. Name: John Kummur
13. Birthplace: Switzerland (City, town, or county) (State or foreign country)
14. Maiden name: Susan ---------
15. Birthplace: Switzerland (City, town, or county) (State or foreign country)
16. (a) Informant: Mildred Kummur
(b) Address: Route 3, Ava, Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-12-44 (Month) (Day) (Year)
(c) Place: burial or cremation: Ellison
18. (a) Signature of funeral director: Clinkingbeard Funeral Home
(b) Address: Ava, Missouri
19. (a) 5-1-1944 (Date received local registrar) (b) Mrs. J. R. Spurlock Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 10 year 1944 hour 5 minute 30 P. M.
21. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__; that I last saw h. alive on ____, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
exhaustion of old age	
was attended by Dr	
Due to at this time	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

162 f

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? (Specify type of place)
While at work? (e) Means of injury: 4
23. Signature: Mrs. J. R. Spurlock Deputy Registrar (M. D. or other)
Address: Ava, Mo. Date signed 5-1-44

1056 (Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 6,
District File Number 544-596
Date Filed MAY 17 1944

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 W B Hutchison

Licensed Embalmer No. 3431

P. O. Address Ona Fla

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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-43
X36930

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 101 Primary Registration District No. 3406 Registrar's No. 36

1. PLACE OF DEATH

(a) County Douglas

(b) City or town Ozu Rural - Lincoln
(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 years, months or days)

In this community .....

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 .....

3. (a) PRINT FULL NAME Samuel E. Kummer

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 June 4 1868
(Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days ..... If less than one day: hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
14. Maiden name .....
15. Birthplace ..... (City, town, or county) ..... (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) 6-15-1944 (Date received local registrar) (b) Mrs. G. R. Spurlock Deputy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day ..... year 1944 hour ..... minute ..... M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions ..... (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
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? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY

17911.