

No. 2
8-43
17-39
X37823

FILED JAN 10 1945

Primary Registration District No. **3010**

Registrar's No. **414**

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Southeast Missouri Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 10 hours
(Specify whether years, months or days)

In this community Entire life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Capitularian

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. West of Cape Riv.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **HOWARD NEAL SUMMERS**

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan 17, 1943
(Month) (Day) (Year)

8. AGE: Years 1 Months 10 Days 14
If less than one day hr. min.

9. Birthplace Cape Girardeau Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name William Summers

13. Birthplace Mellsville Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Viola Slinkard

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

16. (a) Informant William Summers

(b) Address Cape Girardeau Mo. #1

17. (a) Burial (b) Date thereof Dec 13, 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director J. Miller

(b) Address Jackson Mo.

19. (a) 12-16-44 (b) F. W. Phelps
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 11
year 1944 hour 3 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec 11 1944 to Dec 11 1944

that I last saw h. i. m. alive on Dec 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death meningitis Duration 24 hr
Cerebro spinal

Due to cellulitis of rt eye 36 hr

Due to fall on face

Other conditions (include pregnancy within 3 months of death) _____

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

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?

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

23. Signature T. E. Ruff (M. D. or other) MD

Address Jackson Mo. Date signed 12-14-44

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 145-64

Date Filed 1-8-48

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 J. E. Graham

Licensed Embalmer No. 4010

P. O. Address Luttrell, Va

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.

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 414

1. PLACE OF DEATH:

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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 Howard N. Summer

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 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 17 (Month) (Day) (Year)

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

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

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) _____ (Registrar's signature)
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Cape Gir
(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____
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) accident
(b) Date of occurrence Dec 10 1944
(c) Where did injury occur? Home (City or town) _____ (County) _____ (State) _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home
While at work? play (Specify type of place) _____ (e) Means of injury Fall

23. Signature J. Ruff (M. D. or other) MD
Address Jackson Date signed 3-21-45

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

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

