No. 2
4-13-40
5-17-39
I X23159

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 1945

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

17033

State File No.

Registration District No. 135

Primary Registration District No. 3022

Registrar's No. 40

1. PLACE OF DEATH:
(a) County Harrison
(b) City or town Bethany, Missouri.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bethany Hospital
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Harrison
(c) City or town Cainsville, 41
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Donna Gale Summers

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife

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

7. Birth date of deceased December (Month) 25 (Day) 1943. (Year)

8. AGE: Years 1 Months 4 Days 4 If less than one day hr. min.

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

10. Usual occupation Infant

11. Industry or business

MOTHER FATHER
12. Name Lawson Summers
13. Birthplace Harrison (City, town, or county) Missouri (State or foreign country)

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

16. (a) Informant Lawson Summers
(b) Address Cainsville, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April (Month) 30 (Day) 1945 (Year)
(c) Place: burial or cremation Zoar Cemetery

18. (a) Signature of funeral director [signature]
(b) Address Cainsville, Missouri.

19. (a) May 1st 1945 (Date received local registrar) (b) Zola M. Burris (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th year 1945. hour 12 minute 30 P M.

21. I hereby certify that I attended the deceased from April 29- 11 a m, 1945, to April 29 12:30, 1945; that I last saw her alive on April 29, 1945; and that death occurred on the date and hour stated above.

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

Major findings:
Of operations ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED
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 [signature] (M. D.)
Address Cainsville, Missouri. Date signed 4/29/45

303

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11
District File Number
Date Filed

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 Eddie J. Stoklasa Registered Apprentice No. working under my personal supervision.

Signed: E. J. Stoklasa

Licensed Embalmer No. 3602

P. O. Address Cainsville, Missouri

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.

S. No. 2B
OM—5-43
I 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. June

Registration District No. 133 Primary Registration District No. 3022 Registrar's No. 40

1. PLACE OF DEATH:

(a) County Harrison

(b) City or town Bethany
(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)

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 Donna G. Summer

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 25 (Day) 1943 (Year)

8. AGE: Years 1 Months 4 Days If less than one day min.

9. Birthplace (City, town, or county) Mo (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 29
year 1945 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.

Immediate cause of death

Due to Father did not see the Child. Skull was crushed

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 17 5d-8 19

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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) Accident

(b) Date of occurrence Run over by farm tractor

(c) Where did injury occur? at Home (City or town) Harrison (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On farm Home near Cainsville Mo
(Specify type of place)

While at work? (e) Means of injury

23. Signature D. S. Duff (M. D. ~~or other~~)

Address Cainsville Mo Date signed June 19-45

SUPPLEMENTARY

17033