

FILED AUG 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29036

317

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. 6076 Registrar's No. 1902

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) Florissant		c. CITY (If outside corporate limits, write RURAL and give township) Florissant 4050	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hwy 99 R1 Box 331		4. STREET ADDRESS (If rural, give location) Hwy 99 R1 Box 331	

3. NAME OF DECEASED (Type or Print) a. (First) Oliver b. (Middle) H. Kummer c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Aug 6th, 1950		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Apr 17th, 1894	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) St. Louis Co.	
13a. FATHER'S NAME Herman Kummer			13b. MOTHER'S MAIDEN NAME Augusta Hagen		14. NAME OF HUSBAND OR WIFE Bettie Kummer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----		17. INFORMANT'S SIGNATURE OR NAME Bettie Kummer, R1 Box 331 Florissant ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) _____ DUE TO (c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					151X

19a. DATE OF OPERATION 1948	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK? <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **7-12, 1950**, to **8-6, 1950**, that I last saw the deceased alive on **8-3, 1950**, and that death occurred at **7:45 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE M. D. Johnson M.D. (Degree or title)		23b. ADDRESS Ferguson		23c. DATE SIGNED 8-7-50
24a. BURIAL / CREMATION REMOVAL (Specify) Burial	24b. DATE 8/9/50	24c. NAME OF CEMETERY OR CREMATORY Salem Lutheran Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL REG. AUG 8 1950	REGISTRAR'S SIGNATURE Robert L. ...	25. FUNERAL DIRECTOR'S SIGNATURE Diedrich F. Home ADDRESS 8319 Hallsferry	
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WRITE PLAINLY—USING 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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Elmo A. Padwell

Licensed Embalmer No. 4077

P. O. Address.....

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.