

FILED OCT 7 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30855

State File No. 4387

BIRTH NO. 62254-54 REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4387

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death.) a. STATE KANSAS b. COUNTY Wyandotte	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Kansas City)	c. LENGTH OF STAY (in this place) 4 days	c. CITY (If outside corporate limits, write RURAL and give township) Holiday	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		d. STREET ADDRESS (If rural, give location) 8150 8	

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) S. c. (Last) Summers			4. DATE OF DEATH (Month) (Day) (Year) Sept. 14 1954	
----------------------------------------------------------------------------------------------------------------------	--	--	---------------------------------------------------------------	--

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, Never married	8. DATE OF BIRTH Aug. 31 1954	9. AGE (In years last birthday) 15	IF UNDER 1 YEAR Months 15	IF UNDER 2 HRS. Hours Days
--------------------	-------------------------------	--------------------------------------------------------------------	--------------------------------------	-------------------------------------------	----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY Baby	11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.
---------------------------------------------------------------------------------------------------------	--	-----------------------------------------------	----------------------------------------------------------------------------	--	-------------------------------------------

13a. FATHER'S NAME Cecil S. Summers		13b. MOTHER'S MAIDEN NAME Mamie Jo Bradshaw		14. NAME OF HUSBAND OR WIFE None	
--------------------------------------------	--	----------------------------------------------------	--	-----------------------------------------	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Cecil S. Summers Father (Holiday K6)		
----------------------------------------------------------------------------------------------------------------------	--	-------------------------------------	---------------------------------------------------------------------------------------	--	--

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Aspiration pneumonia		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES		7630	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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.		7 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input 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) m.		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 9/11, 1954, to 9/14, 1954, that I last saw the deceased alive on 9/13, 1954, and that death occurred at 7:15 A. m., from the causes and on the date stated above.

23a. SIGNATURE R.R. Becker MD		23b. ADDRESS 4000 Baltimore K.C., Mo		23c. DATE SIGNED 9/14/54	
--------------------------------------	--	---------------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Sept. 14 1954	24c. NAME OF CEMETERY OR CREMATORY Maple Hill Cemetery		24d. LOCATION (City, town, or county) (State) Kansas City, Kansas
-------------------------------------------	--	--------------------------------	---------------------------------------------------------------	--	--------------------------------------------------------------------------

DATE REC'D BY LOCAL REG. 9-14-54		REGISTRAR'S SIGNATURE Merna Minshall		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Simmons Funeral Home KCK	
-----------------------------------------	--	---------------------------------------------	--	--------------------------------------------------------------------------	--

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: Max E. Meyer

Licensed Embalmer No. 4555

P. O. Address K. E. Ks.

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.