

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH.

FILED NOV 1 - 1954

36028

State File No. ....  
9672

BIRTH NO. <u>74657-54</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>St. Louis</u>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>				STREET ADDRESS (If rural, give location) <u>26 812 Chambers Street</u> <u>22690</u>			
3. NAME OF DECEASED (Type or Print) <u>Glenn</u>		a. (First)		b. (Middle)		c. (Last) <u>Summers</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>10 23 54</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>	
8. DATE OF BIRTH <u>Sept 28th, 1954</u>		9. AGE (In years last birthday) <u>25</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.,</u>		12. CITIZEN OF WHAT COUNTRY? <u>0</u>	
13a. FATHER'S NAME <u>John E. Summers</u>		13b. MOTHER'S MAIDEN NAME <u>Lorene Fowler</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J. E. Summers 812 Chambers Street</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Intra-cranial hemorrhage,</u> ANTECEDENT CAUSES <u>Cause unknown</u> 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.				INTERVAL BETWEEN ONSET AND DEATH, <u>Uncertain</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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)		21f. HOW DID INJURY OCCUR? <u>7600</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>10-16, 1954</u> , to <u>10-23, 1954</u> , that I last saw the deceased alive on <u>10-23, 1954</u> , and that death occurred at <u>1:25 A.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Mary A. Davis, M.D.</u>		23b. ADDRESS <u>1515 Lafayette, St. Louis</u>		23c. DATE SIGNED <u>10/23/54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10/26/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.,</u>	
DATE REC'D BY LOCAL REG. <u>OCT 25 1954</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leidner Und. Co. 2223 St. Louis Ave.</u>			

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

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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.....  
Signature of Student Embalmer

Signed..... *G. W. Wilkinson*

Licensed Embalmer No..... *3*

P. O. Address..... *M. Lou*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.