

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010239  
State File No.

FILED MAR 23 1959

REG. DIST. NO. 238 PRIMARY REG. DIST. NO. 4355 Registrar's No. 6

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

1. PLACE OF DEATH a. COUNTY <u>New Madrid</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>New Madrid</u>		c. LENGTH OF STAY (In this place) <u>0731</u> c. CITY OR TOWN <u>New Madrid</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>		e. STREET ADDRESS (If rural, give location) <u>204 Tenn. St.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Amanda</u> b. (Middle) <u>Kate</u> c. (Last) <u>Summers</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 3, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 28, 1909</u>
9. AGE (In years last birthday) <u>50</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u>	IF UNDER 14 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and State or Foreign Country) <u>New Madrid, Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>W.C. West</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Dorsey</u>		14. NAME OF HUSBAND OR WIFE <u>Shirley Clay Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Shirley Clay Summers, New Madrid, Mo.</u>		ADDRESS <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Fatigue</u>		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Mitral Regurgitation</u>	
DUE TO (c) <u></u>		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>HIX</u>	
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 <u>May 12, 1943</u> to <u>March 3, 1959</u> , that I last saw the deceased alive on <u>March 3, 1959</u> , and that death occurred at <u>5:30 P.</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>O.B. Chandler</u> (Degree or title) <u>MD</u>		23b. ADDRESS <u>New Madrid Mo</u>	
23c. DATE SIGNED <u>3/9/59</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9 March 59</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fannie Powell Cemetery New Madrid, Missouri</u>	
24d. LOCATION (City, town, or county) (State) <u>New Madrid, Missouri</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Richards Undertaking Co.</u> ADDRESS <u>New Madrid, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>9 Mar 59</u>		REGISTRAR'S SIGNATURE <u>Fay Hedgcock</u>	

*P. J. S.*

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 *Tommy L. Roberts*.....

Licensed Embalmer No. *4986*

P. O. Address *Ned Medical*.....

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.