URL DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS OCT 13 1959

59-033038
STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 170

1. PLACE OF DEATH
a. COUNTY Macon
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Callao
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION —
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY Macon
c. CITY OR TOWN Callao
Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location)
Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: Corder Middle: Summers Last:
4. DATE OF DEATH Month: 8 Day: 17 Year: 59

5. SEX Male
6. COLOR OR RACE White
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 12-26-86
9. AGE (last birthday) 72
IF UNDER 1 YEAR Months Days; IF UNDER 24 HR 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 —
11. BIRTHPLACE (City and state or country) Callao Mo
12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Wm Summers
13b. MOTHER'S MAIDEN NAME Mary Redman
14. NAME OF HUSBAND OR WIFE —

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. 710-01-8324
17. INFORMANT Billy Summers Address Callao Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterio-Sclerosis
DUE TO (c) Senility
INTERVAL BETWEEN ONSET AND DEATH 3 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 1958, to Aug 1959 and last saw him alive on 8/11/59
Death occurred at 8 PM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE C E Sharp (Degree or title) DO
22b. ADDRESS Callao Mo
22c. DATE SIGNED 9/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Buried
23b. DATE 8-19-59
23c. NAME OF CEMETERY OR CREMATORY Newnan Cem
23d. LOCATION (City, town, or county) Callao (State) Mo

24. FUNERAL DIRECTOR W. T. Edwards ADDRESS Bevier Mo
25. DATE RECD. BY LOCAL REG. 10/5/59
26. REGISTRAR'S SIGNATURE Ruth McNeely

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by r

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed J. S. Edwards

Signature of Student Embalmer

Licensed Embalmer No. 1561

P. O. Address Bevier, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com 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.