URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-040404

FILED VS NOV 17 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5299 STATE FILE NUMBER

MENDED

1. PLACE OF DEATH
a. COUNTY Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City — Length of stay in 1b 4 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Joseph Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Oklahoma b. COUNTY Tulsa Co.
c. CITY OR TOWN Tulsa, Oklahoma — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) ~~6829 Agnes~~ — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First ANNIE Middle MAY Last SUMMERSKILL
4. DATE OF DEATH Month 11 Day 3 Year 59

5. SEX Fe
6. COLOR OR RACE Wh
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 10-1-73
9. AGE (last birthday) 86 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (City and state or country) Cooper County, Mo
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME No Record
13b. MOTHER'S MAIDEN NAME No Record
14. NAME OF HUSBAND OR WIFE Chas. Thomas Summerskill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) XX
16. SOCIAL SECURITY NO. None
17. INFORMANT Waldo T. Summerskill, Address 6829 Agnes, KCMo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MECHANICAL INTESTINAL
DUE TO (b) OBSTRUCTION OF ILEUM
DUE TO (c) (TORSION c̄ STRANGULATION c̄ RESECTION)
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS

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 10-26-58, to 11-3-59 and last saw her/him alive on 11-2-59
Death occurred at 1:00 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) D. C. Quistgard MD
22b. ADDRESS 6741 Prospect KC Mo
22c. DATE SIGNED 11-3-59

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 11-5-59
23c. NAME OF CEMETERY OR CREMATORY Walnut Grove Cem.
23d. LOCATION (City, town, or county) Boonville (State) Mo

24. FUNERAL DIRECTOR Wagner Funeral Home, ADDRESS K. C. Mo.
25. DATE RECD. BY LOCAL REG. 11-3-59
26. REGISTRAR'S SIGNATURE Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF P. C. Quistgard

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_____ Signed Neal William Davis

Signature of Student Embalmer

Licensed Embalmer No. 4195

P. O. Address K.C. Mo.

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