

FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-040562

FILED VS DEC 9 1959

STATE FILE NUMBER

Registration District No. 150 Primary Registration District No. 5572 Registrar's No. 270

ENDED

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rural Prairie		Length of stay in 1b 1 mo.	c. CITY OR TOWN Kansas City Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Jackson County Hosp.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3534 Garfield Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Samuel Middle Y Last Cummings			4. DATE OF DEATH Month November Day 28 Year 1959	
---	--	--	--	--

5. SEX male	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/15/1903	9. AGE (last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
-----------------------	----------------------------------	---	---------------------------------------	-------------------------------------	---	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver	10b. KIND OF BUSINESS OR INDUSTRY Cab Co.	11. BIRTHPLACE (City and state or country) Adrian, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	---	--

13a. FATHER'S NAME Samuel H. Cummings	13b. MOTHER'S MAIDEN NAME Effie Young	14. NAME OF HUSBAND OR WIFE Divorced
---	---	--

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. 513-203456	17. INFORMANT Mrs. Mildred Johnston, Sacramento Calif.
--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma DUE TO (b) carcinoma of larynx DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	---	--

20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____	Month, Day, Year _____
---	------------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 **10-9-59** to **11-28-59** and last saw her/him alive on **11-28-59**
Death occurred at **7:50 A.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Phil Laper M.D.</i>	22b. ADDRESS <i>Lee's Summit, Mo</i>	22c. DATE SIGNED <i>11/30/59</i>
--	---	-------------------------------------

23a. BURIAL OR CREMATION REMOVAL (Specify) Burial	23b. DATE Nov. 3, 1959	23c. NAME OF CEMETERY OR CREMATORY Crescent Hill Cemetery	23d. LOCATION (City, town, or county) (State) Bates County, Missouri
---	----------------------------------	---	--

24. FUNERAL DIRECTOR Langsford Funeral Home	ADDRESS Lee's Summit Missouri	25. DATE RECD. BY LOCAL REG. 12-1-1959	26. REGISTRAR'S SIGNATURE <i>N.B. Langsford</i>
---	---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MS DEC 9 1959

MS DEC 9 1959

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 *W. B. Langford*
Licensed Embalmer No. 3833

P. O. Address *Lis Sumner*

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.