

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012066

FILED VS APR 14 1960

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 69

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Phelps</b>		b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Rolla</b>		a. STATE <b>Missouri</b>		b. COUNTY <b>Dent</b>	
Length of stay in 1b <b>10 days</b>		c. CITY OR TOWN <b>Rolla</b>		c. CITY OR TOWN <b>Salem</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>McFarland Nursing H.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>7th street</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First <b>Lee</b>		Middle <b>- Summers</b>		Last <b>- Summers</b>		Month Day Year <b>March 31 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-88</b>	9. AGE (last birthday) <b>71</b>	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) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>general</b>		11. BIRTHPLACE (City and state or country) <b>Dent Co Mo</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>	
13a. FATHER'S NAME <b>Andy Summers</b>			13b. MOTHER'S MAIDEN NAME <b>Amanda Caroline Steward</b>			14. NAME OF HUSBAND OR WIFE <b>Ethel Cape Summers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>X</b>		17. INFORMANT <b>Sylvester Summers</b>		
						Address <b>Salem Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>20 3 yrs.</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus</b>						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 a.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 <u>3-21-60</u> to <u>3-31-60</u> and last saw him alive on <u>3-31-60</u> Death occurred at <u>11:45 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>E. E. F. [Signature]</b>				22b. ADDRESS <b>Rolla mo.</b>		22c. DATE SIGNED <b>4-6-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>4-4-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miner</b>		23d. LOCATION (City, town, or county) <b>Dent Co Missouri</b>		(State)	
24. FUNERAL DIRECTOR <b>Spencer Funeral Home Inc</b>			ADDRESS		25. DATE RECD. BY LOCAL REG. <b>Apr. 7, 1960</b>	26. REGISTRAR'S SIGNATURE <b>Nadene L. Stoll</b>	

DOCUMENT

MEDICAL CERTIFICATION

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  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Orville J. [Signature]

Licensed Embalmer No. 2370

P. O. Address [Signature]

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.