

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-008188

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 4168 Registrar's No. _____

FILED APR 5 1961

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maysville</u>		c. CITY OR TOWN <u>Maysville</u>	
Length of stay in 1b <u>8 mos.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunset Rest Home</u>		d. STREET ADDRESS (If outside, give location) _____	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Victor</u> Middle <u>J.</u> Last <u>Cummings</u>			4. DATE OF DEATH <u>Mar. 30, 1961</u> Month <u>Mar.</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-19-1876</u>	9. AGE (last birthday) <u>84 years</u>	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) <u>Pot office Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Whomus & Co.</u>		11. BIRTHPLACE (City and state or country) <u>Clinton Co. Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>Porter J. Cummings</u>			13b. MOTHER'S MAIDEN NAME <u>Not known</u>			14. NAME OF HUSBAND OR WIFE <u>Laura Lee Cummings</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>W.T. Wilkinson, Stewartsville, Mo</u> Address _____	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from duodenal ulcer</u> 1-2 hrs			INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerosis general</u> years					
DUE TO (c) <u>Hypertrophy of prostate</u> years					
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 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 _____
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21. I attended the deceased from Jan 10 1961 to Mar 30 1961 and last saw him alive on March 30, 1961
Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. Horweiger M.D.</u> (Degree or title)	22b. ADDRESS <u>Maysville, Mo</u>	22c. DATE SIGNED <u>3/31/61</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4-3-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St Joseph Memorial Park</u>	23d. LOCATION (City, town, or county) <u>St Joseph Mo</u>
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24. FUNERAL DIRECTOR <u>W.B. Summerfield</u> ADDRESS <u>Stewartsville</u>	25. DATE RECD. BY LOCAL REG. <u>4-1-61</u>	26. REGISTRAR'S SIGNATURE <u>Bertie E. Davidson</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 7 1961

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 E Summerfield

Licensed Embalmer No. 3007

P. O. Address Stuartsville Md

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.