

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-041289

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5702

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	a. STATE Missouri	b. COUNTY Line
Length of stay in 1b 6 days		c. CITY OR TOWN Brookfield	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital		d. STREET ADDRESS 212 North Main	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			
First Fred	Middle A.	Last Sumner	Month Nov.	Day 13,	Year 1961	

5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Jan. 10, 1907	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months: Days: Hours: Min.	IF UNDER 24 HR Hours: Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant	10b. KIND OF BUSINESS OR INDUSTRY Paint Business	11. BIRTHPLACE (City and state or country) Detroit, Michigan	12. CITIZEN OF WHAT COUNTRY U. S.
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13a. FATHER'S NAME Carl Sumner	13b. MOTHER'S MAIDEN NAME Francos Featherson	14. NAME OF HUSBAND OR WIFE Lucille Sumner
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mo. Lucille Sumner 212 N. Main Brookfield
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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:		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
IMMEDIATE CAUSE (a) cerebral thrombosis		
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 (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
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19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)
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20c. TIME OF INJURY Hour: _____ a.m. / p.m. Month, Day, Year: _____
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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 Nov. 7, 1961 **to** Nov. 13, 1961 **and last saw her/him alive on** Nov. 13, 1961
Death occurred at 8:25P. **m on the date stated above, and to the best of my knowledge, from the causes stated.**

22a. SIGNATURE (Degree or title) <i>Doctor W. Benoit</i>	22b. ADDRESS 4820 Nichols Pkwy.	22c. DATE SIGNED 11-13-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Nov. 14, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cem.	23d. LOCATION (City, town, or county) (State) Brookfield, Mo.
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24. FUNERAL DIRECTOR Harold Bell Wright	ADDRESS Brookfield, Mo.	25. DATE RECD. BY LOCAL REG. 11-14-61	26. REGISTRAR'S SIGNATURE <i>Ruth Long</i>
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(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Doctor W. Benoit, MEDICAL CERTIFICATION

JAN 5 1962

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

Samuel W. Pearson

Licensed Embalmer No. *4889*

P. O. Address *J.C. 469*

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.