

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

774-62-006733  
STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

**FILED FEB 28 1962**

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Length of stay in 1b <b>38 YEARS</b>	c. CITY OR TOWN <b>KANSAS CITY</b>
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>4125 INDEPENDENCE AVE. KELLY NURSING HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>300 SOUTH ELMWOOD AVE.</b>

3. NAME OF DECEASED (Type or print) First Middle Last <b>FINIS LEE SUMMERS</b>			4. DATE OF DEATH Month Day Year <b>FEBRUARY 7 1962</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 checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/26/79</b>	9. AGE (last birthday) <b>82</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.

10. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELEVATOR OPERATOR &amp; MAINTENANCE</b>		11. BIRTHPLACE (City and state or country) <b>MACON COUNTY, MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
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13a. FATHER'S NAME <b>W. R. SUMMERS</b>		13b. MOTHER'S MAIDEN NAME <b>PHOEBE ELLEN VASS</b>		14. NAME OF HUSBAND OR WIFE <b>ANNIE ELLIZABETH SUMMERS</b>	
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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) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT <b>MALCOLM N. G. SUMMERS K.C., MO.</b>	
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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 <b>1 wk</b>
IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			
DUE TO (b) <b>Coronary &amp; Myocardial Insufficiency</b>			
DUE TO (c) <b>Right Femoral Neck Fracture</b>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a) <b>Right femoral neck fracture</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 type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <b>Fell in Home.</b>			
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20c. TIME OF INJURY Hour a.m. p.m. <b>Mar-7-61</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				
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20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City, Jackson MO</b>
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21. I attended the deceased from <b>Mar-7-61</b> to <b>Feb-7-62</b> and last saw him alive on <b>Jan-24-62</b>	
Death occurred at <b>10:30 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <b>Carl H. Brust m.d.</b>	22b. ADDRESS <b>16014th St. E. C. mo</b>	22c. DATE SIGNED <b>Feb-7-62</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>FEB. 9, 1962</b>	23c. NAME OF CEMETERY OR PLACE OF INTERMENT <b>FOREST HILL CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>KANSAS CITY MISSOURI</b>
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24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>	ADDRESS <b>1331 BRUSH CR. KANSAS CITY, MO.</b>	25. DATE RECD. BY LOCAL REG. <b>2-9-62</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed

*Robert Ray*

Licensed Embalmer No. 4182

P. O. Address K. C., Mo.

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.