

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-042128

STATE FILE NUMBER

Registration District No. 098 Primary Registration District No. _____ Registrar's No. 8

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

<p style="font-size: 18pt; font-weight: bold;">FILED DEC 12 1962</p> <p>1. PLACE OF DEATH a. COUNTY <u>Davies</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Davies</u></p>	
<p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Gallatin</u></p>		<p>c. CITY OR TOWN <u>Gallatin</u></p>	
<p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u></p>		<p>d. STREET ADDRESS (If outside, give location) <u>_____</u></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS (WMI) SUMMERS</u></p>		<p>4. DATE OF DEATH Month Day Year <u>12 6 1962</u></p>	
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>	
<p>7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>3-12-1874</u></p>	
<p>9. AGE (last birthday) <u>88</u></p>		<p>IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Farmer</u></p>	
<p>11. BIRTHPLACE (City and state or country) <u>Waller, Ind</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>	
<p>13a. FATHER'S NAME <u>J. Summers</u></p>		<p>13b. MOTHER'S MAIDEN NAME <u>Analys Cunningham</u></p>	
<p>14. NAME OF HUSBAND OR WIFE <u>Adler Summers</u></p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>no</u></p>	
<p>17. INFORMANT <u>Earl Summers - Pattonburg Mo</u></p>		<p>Address <u>_____</u></p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia</u></p>			<p>INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u></p>
<p>CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) <u>Senility</u></p>			
<p>DUE TO (c) <u>_____</u></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>_____</u></p>			<p>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</p>
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>	
<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>_____</u></p>			
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>_____</u></p>			
<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>_____</u></p>	
<p>20f. CITY, TOWN, OR LOCATION <u>_____</u></p>		<p>COUNTY STATE <u>_____</u></p>	
<p>21. I attended the deceased from <u>Nov. 28, 62</u> to <u>12-6-62</u> and last saw ^{her} him alive on <u>12-6-62</u> Death occurred at <u>6:50 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>			
<p>22a. SIGNATURE <u>Flora E. Melanick</u></p>		<p>22b. ADDRESS <u>Gallatin, MO</u></p>	
<p>22c. DATE SIGNED <u>12-7-1962</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE <u>12-9-62</u></p>	
<p>23c. NAME OF GEMETERY OR CREMATORY <u>Coffey</u></p>		<p>23d. LOCATION (City, town, or county) <u>Coffey Mo</u></p>	
<p>24. FUNERAL DIRECTOR <u>Walter Brown</u></p>		<p>25. DATE RECD. BY LOCAL REG. <u>Dec 7, 1962</u></p>	
<p>ADDRESS <u>Pattonburg Mo</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>Reginald Engelhart</u></p>	

USE BLACK INK OR TYPEWRITER RIBBON

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

*Permit obtained 12-10-22
No. 4 B*