AUG 23 1929

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

24032

1. PLACE OF DEATH
County Cape Girardeau Registration District No. 129
Township Jackson Primary Registration District No. 5180
City ..... (No. ..... St. ..... Ward)

File No. 4
Registered No. 16

2. FULL NAME Eugene E Summers

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	white	Child

5a. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF Child

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 1 1922

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	1	18	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Cape Gir. Co Mo
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Jesse Summers
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Kentucky
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER Addie McConnell
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Missouri
(STATE OR COUNTRY)

14. INFORMANT Glenn Summers
(Address) Medoc Cape Co Mo

15. FILED Aug 7 1929 Fred DeShone
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 18 1929

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 18, 1929, that I last saw him alive on July 17, 1929, and that death occurred, on the date stated above, at 5 o'clock A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Meningitis

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (SECONDARY) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) O J Miller, M. D
7-18, 1929 (Address) Egypt Mills Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Jona Cemetery — DATE OF BURIAL 7-19-1929

20. UNDERTAKER McCormack F.H. — ADDRESS Jackson Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

U. S. No. 2.