

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

Do not use this space.

3039

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... City Registration District No. 1003
 City St. Louis (No. City Hospital #2)..... St. Ward)

File No.
 Registered No. F 640

2. FULL NAME

Henrietta Lumphkins

(a) Residence, No. 109 S. 20th St., Ward. (If nonresident give city or town and State)
 (Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Henry Lumphkins

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 4, 1900

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
27 | 6 | 1

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

10. NAME OF FATHER Robert Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Miss.

12. MAIDEN NAME OF MOTHER Mattie Hughes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT (Address) Anna J. Woodard
City Hospital #2

15. FILED Jan 18 1928 maud s. arney

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 5, 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1928 to Jan 5 1928 that I last saw her alive on Jan 5 1928, and that death occurred, on the date stated above, at 11:30 a.m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Cerebral apoplexy
82 H
Chart (duration) yrs. mos. 6 ds.

CONTRIBUTORY (SECONDARY) 7401 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED not known
 IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS autopsy
 (Signed) Dr. Family M. D.
 , 19 (Address) City Hospital #2

*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 Washington Park DATE OF BURIAL 1-18-1928

20. UNDERTAKER J.S. Wade & Son ADDRESS 4202

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

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.

