

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

Do not use this space.

**1. PLACE OF DEATH**

County.....  
Township.....  
City *Morris Mo* No. *St. Johns Hospital*

Registration District No. *791*  
*1003*

File No. *21880*  
Registered No. *6001*  
St. .... Ward)

**2. FULL NAME**

*Dr. David E. Fumall*  
(a) Residence. No. *4902<sup>a</sup> Devonshire St.* *14* 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 *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Divorced*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Divorced*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 15 - 1873*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min. <i>9 1/2</i>
	<i>55</i>	<i>4</i>	<i>17</i>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Physician 821*  
(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) *Ohio*

10. NAME OF FATHER *David E. Fumall*

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

12. MAIDEN NAME OF MOTHER *Unknown Oliver*

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

14. INFORMANT *David E. Fumall Jr*  
(Address) *4902<sup>a</sup> Devonshire*

15. FILED.....

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *June 2 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 7.5.28*, 1928, to *June 2nd*, 1928 that I last saw him alive on *June 2nd*, 1928, and that death occurred, on the date stated above, at *11.45 P.M.*

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

*cerebral Embolus*  
*880*  
CONTRIBUTORY (SECONDARY) *Acute Streptococcus*  
*Endocarditis* (duration) yrs. *5* mos. *8* ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *No*. DATE OF.....

WAS THERE AN AUTOPSY? *No*.

WHAT TEST CONFIRMED DIAGNOSIS? *Clinical & Laboratory examinations*  
(Signed) *D. E. Edwards*, M. D.  
*6/4, 1928* (Address) *4216 Shaw Ave*

\*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 *Lakewood Park* DATE OF BURIAL *June 5 1928*

20. UNDERTAKER *Hubertus and Co* ADDRESS *4234*

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.

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