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

Do not use this space.

12404

File No. .....
Registered No. 2525

1. PLACE OF DEATH

County ..... Registration District No. 703
Township ..... Primary Registration District No. 703
City Glendale (No. City Hospital ..... St. ..... Ward)

2. FULL NAME Albert Stump

(a) Residence. No. 1417 A7 St., 23 Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 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): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 15 - 1876

7. AGE: Years 52 | Months 5 | Days 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 237
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Cincinnati, 8
(STATE OR COUNTRY) Ohio

PARENTS

10. NAME OF FATHER Wm Stump
11. BIRTHPLACE OF FATHER (CITY OR TOWN) 2
(STATE OR COUNTRY) Ohio
12. MAIDEN NAME OF MOTHER Unknown 2
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) 2
(STATE OR COUNTRY) Ohio

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED ....., 19.... Mabel C. Hartley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1929

17. I HEREBY CERTIFY, That I attended deceased from March 5, 1929, to March 6, 1929, that I last saw him alive on March 6, 1929, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic myocarditis
Chronic interstitial nephritis
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 1240
(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?

3/6, 1929 (Signed) Edmund R. Sheridan, M. D.
(Address) City Hospital

*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: Cincinnati Ohio — DATE OF BURIAL: Mar. 7 1929

20. UNDERTAKER: Wacker Heldele 2331 — ADDRESS: So Bilway

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.

THIS IS A PERMANENT RECORD

Stump