

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

Do not use this space.

6443

**1. PLACE OF DEATH**

County..... Registration District No. DR  
 Township..... Primary Registration District No. DR  
 City St Louis Mo (No. Missouri Baptist Hospital) (Ward)

File No. ....  
 Registered No. 1235

**2. FULL NAME**

Lawrence Cumberly  
 (a) Residence, No. Ambassador Hotel 25 Ward. ....  
 (Usual place of abode) 707 N 6th St (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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 5<sup>th</sup> 1930

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

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1930 to Feb 5 1930 that I last saw him alive on Feb 5 1930 and that death occurred, on the date stated above, at 10:50 AM m.  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 5<sup>th</sup> 1848

Broncho Pneumonia  
107A

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
81. 5. X.

(duration) yrs. mos. ds. 7  
 CONTRIBUTORY (SECONDARY) 1000 (duration) yrs. mos. ds.

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

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH.....  
 DID AN OPERATION PRECEDE DEATH? No DATE OF.....  
 WAS THERE AN AUTOPSY?.....

9. BIRTHPLACE (CITY OR TOWN) Louisiana (STATE OR COUNTRY) Mo.

10. NAME OF FATHER unknown.

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

12. MAIDEN NAME OF MOTHER unknown.

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

14. INFORMANT Mr. Lyle (Address) Eagle Packet Co.

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) H C Campbell M. D.  
2/5 1930 (Address) 3746 W. Belmont  
 \*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.

15. FILED 19 REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Bellefontaine Cem. DATE OF BURIAL 2-7-1930

20. UNDERTAKER C. R. Lupton ADDRESS 4449 Olive St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

25-3

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PARENTS

REGISTRAR

