

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.

DEC 18 1939

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

40717
 Do not use this space.

1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 773
 (b) Township St. Francois Primary Registration District No. 6018A
 (c) City Near Farmington (d) Street No. State Hospital No. 4 Registered No. 179
 (If death occurred in Hospital or Institution, write its name instead of street and number) St.
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 520 Louise Rumsey
 (a) Residence, No. 134 Park Road, Webster Groves, Mo. su. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Wm. S. Rumsey</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>9-16-1869</u>		
7. AGE YEARS <u>70</u>	MONTHS <u>2</u>	DAYS <u>2</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>		
9. Industry or business in which work was done, as saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Iowa</u>		
FATHER	13. NAME <u>Albert Spencer</u>	
FATHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Wisconsin</u>	
MOTHER	15. MAIDEN NAME <u>Unknown</u>	
MOTHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>11</u>	
17. INFORMANT <u>Records of State Hospt. #4</u> (ADDRESS) <u>Farmington, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Hills</u> DATE <u>Nov 20</u> 19 <u>39</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Perkins Under</u> <u>Webster Groves</u>		
20. FILED <u>Nov 18, 1939</u> <u>T. J. Robinson</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 18, 1939
 22. I HEREBY CERTIFY, That I attended deceased from October 12, 1939, to November 18, 1939
 I last saw h. aw. alive on November 17, 1939. Death is said to have occurred on the date stated above, at 12:25 A.M.
 The principal cause of death and related causes of importance were as follows:
Anteroinfarction, generalized marked cerebral hemorrhages Date of onset 11/11/39
11/17/39
 Other contributory causes of importance:
Paralysis with cerebral arteriosclerosis 1938
bronchopneumonia, terminal 11/17/39
 Name of operation None Date of _____
 What test confirmed diagnosis? Chemical Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____; 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) C. O. Ault M. D.
699 (Address) Farmington, Mo.

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

Orin B. Lang

Licensed Embalmer No. *1581*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.