No. 2
-1/47
-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED DEC 12 1947
Registration District No. 28

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr. Webb
State File No. 37699
Primary Registration District No. 2000
Registrar's No. 1000

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 831 S. Kimbrough
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 34 Years (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene 39
(c) City or town Springfield 2
(If outside city or town limits, write "RURAL") 6
(d) Street No. 831 S. Kimbrough
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country N

3. (a) PRINT FULL NAME Della E. Bumpas
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widowed 2
6. (b) Name of husband or wife George Bumpas
6. (c) Age of husband or wife if alive Dec. years
7. Birth date of deceased Aug. (Month) 6 (Day) 1869 (Year)

8. AGE: Years 78 Months 3 Days 15 If less than one day hr. min.

9. Birthplace Brighton (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation Home
11. Industry or business
FATHER
12. Name George L. Tuck
13. Birthplace Brighton (City, town, or county) Missouri (State or foreign country) 0
MOTHER
14. Maiden name Sarah M. Mitchell
15. Birthplace Morrisville (City, town, or county) Missouri (State or foreign country) 0
16. (a) Informant Mrs. Louise Crump
(b) Address Springfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/47 (Month) (Day) (Year)
(c) Place: burial or cremation Brighton, Mo.
18. (a) Signature of funeral director H.H. Lohmeyer
(b) Address Springfield, Mo.
19. (a) 11-22-47 (Date received local registrar) (b) W. E. Hensley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 21
year 1947 hour 2 minute 30p. M.
21. I hereby certify that I attended the deceased from
Sept. 29, 1930 to November 21, 1947;
that I last saw her alive on November 21, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Miocardia/Insufficiency	4 yrs.
Due to	
Due to	
Other conditions: Colitis and Tuberculosis (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Underline the cause of which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury 0
23. Signature Leslie R. Webb (M. D. or other)
Address 700 Medical Arts Bldg. Springfield, Mo. Date signed Nov. 22, 1947

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

DEC 12 1947

APR 17 1958

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 Roy H. Mercer, Jr.

Licensed Embalmer No. 4432

P. O. Address Springfield, Mo.

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, fact should be so stated above.

No. 2B
M—3-45
X43880

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Dee

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1000

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Della E. Bumpar

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 6 (Day) 86 (Year)

8. AGE: Years 78 Months 3 Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Day 1947 year hour minute M.

21. I hereby certify that I attended the deceased from , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Pulmonary Tuberculosis	3 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

While at work? (e) Means of injury

23. Signature Leslie B. Webb (M. D. or other)

Address Springfield Mo Medarts Bldg Date signed 12-18-47

SUPPLEMENTARY

37699