

FILED MAR 16 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11156
11156
2195
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 5959a Romaine Place	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Deaconess Hospt			
3. NAME OF DECEASED (Type or Print) a. (First) Edith b. (Middle) Florence c. (Last) Stumpf		4. DATE OF DEATH (Month) (Day) (Year) Mar 6 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 23 1874
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Hamilton County Ills		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Franklin Poster		13b. MOTHER'S MAIDEN NAME Nancy Mayberry	
14. NAME OF HUSBAND OR WIFE Louis N. Stumpf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME Louis N. Stumpf		ADDRESS 5959a Romaine Pl	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchiectasis		INTERVAL BETWEEN ONSET AND DEATH Unknown	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis		Unknown	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS		Unknown	
Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4222			
21d. TIME OF INJURY (Month) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 20, 1950, to Mar. 6, 1950, that I last saw the deceased alive on Mar. 6, 1950, and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W. W. WADES		23b. ADDRESS 7602 So. Broadway	
23c. DATE SIGNED 3/7/50			
24a. BURIAL, CREMATION REMOVAL (Specify) Burial		24b. DATE March 9 1950	
24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. MAR 7 1950		REGISTRAR'S SIGNATURE G. B. Ruster	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Jos. W. Clark 1125 Hodiamont Ave	

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

Dr. D.W. Eads

7602 So Broadway

La 3888

1403

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *J. W. Bentley*
Licensed Embalmer No. *3653*

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, fact should be so stated above.