

FILED APR 9 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 10232
2995 Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 100 Registrar's No. _____

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Richland | |
| b. CITY (If outside corporate limits, write RURAL and give town) St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) Olney | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital | | | |

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|-------------------------------------|-------------------|---------------------|-----------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Mattie | b. (Middle) Umfleet | c. (Last) | 4. DATE OF DEATH (Month) (Day) (Year) March 29, 1951 |
|-------------------------------------|-------------------|---------------------|-----------|--|

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|---------------|------------------------|--|--------------------------------|------------------------------------|------------------------|-----------------------------|
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed | 8. DATE OF BIRTH Jan. 11, 1874 | 9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months | IF UNDER 24 hrs. Hours Min. |
|---------------|------------------------|--|--------------------------------|------------------------------------|------------------------|-----------------------------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Richland County, Illinois | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|-----------------------------------|---|----------------------------------|

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|-------------------------------------|-----------------------------------|--|
| 13a. FATHER'S NAME Albert Edmundson | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Nicholas Umfleet |
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| 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 Don Kaiser | ADDRESS 8334 Halls Ferry Road |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 3 days 2-3 yrs 2-3 yrs |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) General Arteriosclerosis | | |
| | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

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|------------------------|----------------------------------|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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|--|--|---|
| 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) |
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| | | |
|--|--|---------------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 331X |
|--|--|---------------------------------|

22. I hereby certify that I attended the deceased from 11/2 1949, to 3/29, 1951, that I last saw the deceased alive on 3/29, 1951, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

| | | |
|---|-----------------------------|--------------------------|
| 23a. SIGNATURE D. L. Mistackin (Degree or title) M.D. | 23b. ADDRESS 3903 Olive St. | 23c. DATE SIGNED 3/30/51 |
|---|-----------------------------|--------------------------|

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|---|-------------------|------------------------------------|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 3-30-51 | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) Sumner, Illinois |
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|--------------------------------------|------------------------------------|--|-------------------------|
| DATE REC'D BY LOCAL REG. MAR 30 1951 | REGISTRAR'S SIGNATURE J. B. Foster | 25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe | ADDRESS 4700 Washington |
|--------------------------------------|------------------------------------|--|-------------------------|

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

STATEMENT BY LICENSED EMBALMER

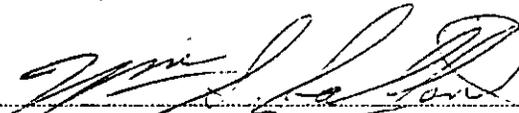
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed



Licensed Embalmer No. 4699

P. O. Address W. Charles, Ill.

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.