

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44350**
Registrar's No. **11741**

FILED DEC 17 1953

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 MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place) 30 YRS	c. CITY OR TOWN ST. LOUIS
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 26 1316 MADISON STREET	
3. NAME OF DECEASED (Type or Print) a. (First) ANDREW b. (Middle) c. (Last) LUMPKIN		4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 11, 1953	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER	8. DATE OF BIRTH 11-28-1873
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED LABORER	11. BIRTHPLACE (City and State or Foreign Country) MURPHYSBORO, ILLINOIS
12. CITIZENSHIP OF WHAT COUNTRY? USA		13a. FATHER'S NAME ANDERSON LUMPKIN	13b. MOTHER'S MAIDEN NAME UNKNOWN
14. NAME OF HUSBAND OR WIFE DECEASED		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. UNKNOWN
17. INFORMANT'S SIGNATURE OR NAME RUBY LINDSAY		ADDRESS 2504 W. HERBERT	
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebroarteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	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 12-7-53 , 19___, to 12-11-53 , 19___, that I last saw the deceased alive on 12-11-53 , 19___, and that death occurred at 8:40A m., from the causes and on the date stated above.			
23a. SIGNATURE O. J. Sheehan, M.D.		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 12-11-53
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12-14-53	24c. NAME OF CEMETERY OR CREMATORY SALVARY CEMETERY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
DATE REC'D BY LOCAL REG. DEC 12 1953	REGISTRAR'S SIGNATURE J. Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Edual Meyer + Sons	
		ADDRESS 3934 W. 26 St.	

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

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed *August W. Guterle*.....

Licensed Embalmer No. *4329*.....

P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.