

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.

STANDARD CERTIFICATE OF DEATH

State File No. 24401

AUG 11 1939

791  
1003

Registration District No.

Primary Registration District No.

Registrar's No.

6674

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: De Paul Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 13 days  
In this community 50 years  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME August Stumm  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. 350  
none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Julia Melvin Stumm 6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased Oct 1st 1867  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>71</u>	<u>9</u>	<u>29</u>	hr. _____ min. _____

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

10. Usual occupation Retired Horseshoer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Henry Stumm  
13. Birthplace Germany  
(City, town, or county) (State or foreign country)  
14. Maiden name Elmer Helfenstein  
15. Birthplace Germany  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Julia Melvin Stumm  
(b) Address Northwestern Hotel

17. (a) Burial (b) Date thereof 8/2/39  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Bellefontaine

18. (a) Signature of funeral director Stroot - Carroll  
(b) Address 4600 Natural Bridge Ave

19. (a) III 31 1939 (b) John B. Buehler  
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4919 Northwestern Hotel  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 50 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30  
year 1939 hour 7 minutes 30 M.

21. I hereby certify that I attended the deceased from July 17, 1939, to July 30, 1939;  
that I last saw her alive on 7-29, 1939  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Multiple Abscess of Liver  
Hyperthrophic Cardiac Liver  
Dued

Due to \_\_\_\_\_

Other conditions 46  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of an operation Multiple Abscess of Liver & Probable Metastases

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

(a) Accident, suicide, or homicide (specify) no

(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? X

While at work? X (Specify type of place) (e) Means of injury 1

23. Signature E. A. Sanchez (M. D. or other)

Address 1865 Natural Bridge Date signed 7-21-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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**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..... *Frank H. Shivers* .....

Licensed Embalmer No. *2265* .....

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.**