

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

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.

17 FEB 25 1941

Registration District No. _____

Primary Registration District No. 1003

1. PLACE OF DEATH: St. Louis, Mo.

(a) County _____

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

(c) Name of hospital or institution: DePaul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County _____

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

(d) Street No. 5129 Maffitt (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME John A. Bumbery

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M. 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillian Bumbery 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased May 16, 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months 8 Days 12 If less than one day hr. _____ min. _____

9. Birthplace St. Louis, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation Horse Shoer

11. Industry or business _____

MOTHER FATHER { 12. Name James Bumbery

13. Birthplace Ireland (City, town, or county) (State or foreign country)

14. Maiden name Catherine Unknown (State or foreign country)

15. Birthplace Ireland (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lillian Bumbery

(b) Address 5129 Maffitt

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/31, 41
(Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Sullivan Bros.
2849 N. Euclid

(b) Address _____

19. JAN 29 1941 (Date received local registrar) (b) J. W. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 28 year 1941 hour 1 minute 50 am. M.

21. I hereby certify that I attended the deceased from 1-23-41, 1941, to 1-28-41, 1941, that I last saw him alive on 1-27-41, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death ac. to Lobar Pneumonia

Due to Influenza

Due to Hypertrophy of heart

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

Major findings: Of operations 33 a

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? _____

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

23. Signature W. W. White (M. D. or other) _____
2803 N. Highway Date signed 1-28-41

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 Albert Mayfield
Licensed Embalmer No. 13077
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.