

SEP 3 1943
318

Registration District No. Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis Mo.**
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: in hospital or institution **1 1/2 Hrs**
(Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **Maplewood Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. **7168 Lyndover**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Clifford F. Bumpass**

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

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

6. (b) Name of husband or wife **Viola Bumpass** 6. (c) Age of husband or wife if alive **35** years

7. Birth date of deceased **Dec 12 1903**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
39 8 13 hr. _____ min.

9. Birthplace **Dixon Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business _____

MOTHER FATHER

12. Name **Ewell Bumpass**

13. Birthplace **Dixon Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Susie Lawson**

15. Birthplace **Dixon Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Viola Bumpass**

(b) Address **7168 Lyndover Maplewood Mo**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Aug 27-1943**
(Monthly) (Day) (Year)

(c) Place: burial or cremation **Oakhill Cemetery**

18. (a) Signature of funeral director **[Signature]**

(b) Address **7156 Manchester Ave Maplewood Mo**

19. (a) **AUG 26 1943** (Date received local registrar) **J. F. [Signature]** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **25** year **1943** hour **2** minute **00**

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Alcoholism**

Due to _____

Due to _____

Other conditions: (Includes pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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)

(a) Means of injury _____

23. Signature **Thomas F. Callahan** (M. D. or other) **8-24-40**

Address **Deputy Coroner** Date _____

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

7C

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

V E Morris

Licensed Embalmer No.....

3360

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.