

FILED SEP 21 1943  
Registration District No. **2**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **St. Louis**  
(If outside city or town limits, give "RURAL" and name of township)

(c) Name of hospital or institution: **5587 Wells Ave.**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. \_\_\_\_\_  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **St. Louis**

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

(d) Street No. **5587 Wells Ave.**  
(If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Albert John Sumner**

MEDICAL CERTIFICATION

3. (b) If veteran, name war **World War #1** 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month **Sept.** day **8**  
year **1943** hour **7:30** minute **P.** M.

4. Sex **Male** 5. Color **Wh** 6. (a) Single **Single**  
divorced \_\_\_\_\_

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.

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years

7. Birth date of deceased **May 30 1893**  
(Month) (Day) (Year)

Immediate cause of death **Chronic Myocardial  
infarct marked by  
degeneration of Wolff  
Pacemaker**

8. AGE: Years **50** Months **3** Days **8** If less than one day \_\_\_\_\_  
hrs. min.

Due to **Chronic Intermittent Nephritis**

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

10. Usual occupation **Disabled World War Veteran**

Major findings: **121**  
Of operations \_\_\_\_\_

11. Industry or business **Frank Sumner**

12. Name **Frank Sumner**

Of autopsy \_\_\_\_\_

13. Birthplace **Havenport Iowa**  
(City, town, or county) (State or foreign country)

14. Maiden name **Katherine Morrow**

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

16. (a) Informant **Ralph L. Sumner**

(b) Address **5267 Thrush**

17. (a) Burial, cremation or removal **Burial** (b) Date thereof **9-11-43**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Jefferson Barracks**

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? \_\_\_\_\_

18. (a) Signature of funeral director **Chas. J. Stuart**

(b) Address **1225 Union Blvd.**

19. (a) **SEP 17 1943** (b) **J. Brodeur**  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature **Thomas J. Callahan** (M. D. or other) **9-8-43**  
Address **Deputy Coroner** Date **Sept 8 1943**

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

MOTHER FATHER

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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.....

*Albert G. Happe*

Licensed Embalmer No..... *2971*

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.**