

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003456  
STATE FILE NUMBER

Registrar 2 734

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before death)  
a. STATE Missouri b. COUNTY Franklin

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri Inside Limits Yes  No

c. CITY OR TOWN Leslie "360" Inside Limits Yes  No

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Length of stay in 1b \_\_\_\_\_

d. STREET ADDRESS (If outside, give location) \_\_\_\_\_ Reside on Farm Yes  No

3. NAME OF DECEASED First Middle Last  
LUCILLE F. RUMBUHL

4. DATE OF DEATH Month Day Year  
JANUARY 21, 1959

5. SEX Female 6. COLOR OR RACE White 7. MARRIED  NEVER MARRIED   
WIDOWED  DIVORCED

8. DATE OF BIRTH Oct. 26, 1898 9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY \_\_\_\_\_ 11. BIRTHPLACE (City and state or country) Gerald, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Berly G. Ficke 13b. MOTHER'S MAIDEN NAME Ida Gerken 14. NAME OF HUSBAND OR WIFE Clay Rumbuhl

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. None 17. INFORMANT Address Mrs. James Copeland, Union, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Rheumatic Heart Disease (Cardiac Decompensation) INTERVAL BETWEEN ONSET AND DEATH 7 years  
(1 year)  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_ 716x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) \_\_\_\_\_ 19. WAS AUTOPSY PERFORMED? YES  NO

20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) \_\_\_\_\_

20c. TIME OF INJURY Hour Month, Day, Year  
a.m. p.m. \_\_\_\_\_

20d. INJURY OCCURRED WHILE AT  NOT WHILE AT WORK  20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1/14/59 to 1/21/59 and last saw her alive on 1/21/59  
Death occurred at 12:15 a.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) F.R. Bradley M. D. 22b. ADDRESS BARNES HOSPITAL 22c. DATE SIGNED 1/21/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 1-21-59 23c. NAME OF CEMETERY OR CREMATORY Local 23d. LOCATION (City, town, or county) (State) Union, Mo.

24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. 25. DATE RECD. BY LOCAL REG. JAN 22 59 26. REGISTRAR'S SIGNATURE J. Carl Smith md  
mdB

300  
1-57  
03  
65

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MAR 30 1959

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 *Robert M. Murray*

Licensed Embalmer No. *5749*

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.