

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030834

FILED VS SEP 11 1959

2 8058

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>De Pauls Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>1203 N. 7th St. Apt. F</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>ZELMA</b> Middle <b>SUMPTER</b> Last				4. DATE OF DEATH Month <b>Aug.</b> Day <b>29</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>June 23 1895</b>	9. AGE (last birthday) <b>64</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Greensburg Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>Robert Wells</b>			13b. MOTHER'S MAIDEN NAME <b>Rose Silvers</b>			14. NAME OF HUSBAND OR WIFE <b>Harvey Sumpter</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Harvey Sumpter 1203 N. 7th St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <b>Myocardial infarct from coronary occlusion.</b>							<b>two minutes.</b>		
DUE TO (b) <b>Metastatic carcinoma of lung from</b>							<b>don't know</b>		
DUE TO (c) <b>left breast.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>none</b>							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>170x</b>							
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>8-15-59</b> to <b>8-29-59</b> and last saw her <del>was</del> alive on <b>8-29-59</b> Death occurred at <b>7 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <b>Walter H. Spoerensman M.D.</b>				22b. ADDRESS <b>1515 St. Louis</b>				22c. DATE SIGNED <b>8-31-59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Sept. 1 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brashear Cemotery</b>			23d. LOCATION (City, town, or county) <b>Brashear, Mo.</b>			(State)	
24. FUNERAL DIRECTOR ADDRESS <b>Leidner Undertaking 2223 St. Louis Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>AUG 31 1959</b>		26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Albert Maguire

Licensed Embalmer No. 13077

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.