

**FEDERAL BUREAU OF INVESTIGATION - UNITED STATES DEPARTMENT OF JUSTICE**  
**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-025295**

**FILED VS JUN 20 1960**

Registration District No. **317** Primary Registration District No. **547** Registrar's No. **1733** STATE FILE NUMBER

UNDECEASED

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights</b>		Length of stay in 1b <b>DAYS</b>		c. CITY OR TOWN <b>University City, (30)</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Marys Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>561 Bedford</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>BLANCHE</b> Middle <b>MORSE</b> Last <b>SUMNIGHT</b>				<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>31</b> , Year <b>1960</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Nov 4, 1889</b>	<b>9. AGE</b> (last birthday) <b>70</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>at home</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Nova Scotia</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>USA</b>	
<b>13a. FATHER'S NAME</b> <b>Elisha Morse</b>			<b>13b. MOTHER'S MAIDEN NAME</b> <b>Alalia Gates</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>Henry Anthony Sumnicht</b>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Livingston, N.J.</b> <b>Mrs. Edward M. Kempner, Jr. 21 Deal Lane</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Hemiplegia</b> DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Mar 16 / 1960</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
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							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Month, Day, Year					
<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY	STATE
<b>21. I attended the deceased from</b> <b>Mar 16, 1960</b> <b>to</b> <b>May 31, 1960</b> <b>and last saw her</b> <b>alive on</b> <b>5-31-60</b> Death occurred at <b>345</b> <b>o</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>D.E. Williamson M.D.</b>				<b>22b. ADDRESS</b> <b>6336 Clayton Road</b>		<b>22c. DATE SIGNED</b> <b>6-1-60</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>burial</b>		<b>23b. DATE</b> <b>June 3, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Oak Grove Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) <b>St. Louis County, Missouri</b>		(State)
<b>24. FUNERAL DIRECTOR</b> <b>C.R. Lupton &amp; Sons; 7233 Delmar Blvd;</b>				<b>25. DATE RECD. BY LOCAL REG.</b> <b>6-2-60</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>J. B. Murphy 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 Arnold W. Schoe

Licensed Embalmer No. 3864

P. O. Address St. Louis,

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.