

S. No. 2  
M-8-43  
v. 5-17-39  
X37823

DEPARTMENT OF COMMERCE  
THE STATE BOARD OF HEALTH OF MISSOURI  
**FILED SEP 7 1945 STANDARD CERTIFICATE OF DEATH**

State File No. **26035**  
Registrar's No. **7548**

Registration District No. \_\_\_\_\_ Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **Bellevue General**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 hour**  
In this community \_\_\_\_\_ years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **000**  
(c) City or town **St. Louis**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **6561 Arco**  
(If rural, give location) **9/18**  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Infant Baby Plowman**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **8** day **14**  
year **1945** hour **3** minute **2** M.

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **0**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **8 14 45**  
(Month) (Day) (Year)

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.

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **Congenital Cystic kidneys (1-bilateral)** Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to **157 hr**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy **Cystic kidneys defective head development**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_  
11. Industry or business \_\_\_\_\_

MOTHER FATHER } 12. Name **Charles Plowman**  
13. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Falsa Myers**  
15. Birthplace **Pomona, Mo**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Hospital Record**  
(b) Address **3649 Viola**  
17. (a) **Burial** (b) Date thereof **8-30-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **City Cemetery**

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

18. (a) Signature of funeral director **V. B. Hudson**  
(b) Address **City Health Dept**  
19. (a) **8-29-45** (b) **J. F. Bredeek**  
(Date received local registrar) (Registrar's signature)

23. Signature **J. F. Bredeek** (M. D. or other) **MD**  
Address **4660 Maryland** Date signed **8/17/45**

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

66  
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9  
102-0292

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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.....

Licensed Embalmer No.....

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.**