

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 15 1951

State File No. 5065

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) 4 Weeks	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2249	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		STREET ADDRESS (If rural, give location) 2804 Indiana Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Mary Ann	b. (Middle)	c. (Last) Plass	4. DATE OF DEATH (Month) (Day) (Year) May 30, 1951
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 24, 1892	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
				59	3 Months	6 Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME James Foley	13b. MOTHER'S MAIDEN NAME Catherine Regan	14. NAME OF HUSBAND OR WIFE Edward Plass
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Edward Plass	ADDRESS 2804 Indiana Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Nephritis & uremia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) no	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 592X
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22. I hereby certify that I attended the deceased from **Nov 11, 1947**, to **May 30, 1951**, that I last saw the deceased alive on **May 30, 1951**, and that death occurred at **11 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE P. Berymd	(Degree or title) 0	23b. ADDRESS 3203 S Grand St. City	23c. DATE SIGNED 6-1-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/2/51	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. JUN 1 1951	REGISTRAR'S SIGNATURE J. B. Pasater	25. FUNERAL DIRECTOR'S SIGNATURE John H. Gebken Sons	ADDRESS 2630 Gravois Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed _____

Robert T. Yelken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.