

pt. Health,
, & Welfare
S. Public
with Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39605

STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 71 Primary Registration District No. 3022 Registrar's No. 100

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| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>McDonald</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs, Mo.</u> | | c. CITY OR TOWN <u>Anderson</u> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <u>Veterans Administration Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>Route 2</u> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>A.</u> Last <u>PLUMMER</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1957</u> | | |
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| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>October 3, 1888</u> | 9. AGE (In years last birthday) <u>69</u> | 10. IF UNDER 1 YEAR Months _____ Days _____ | 11. IF UNDER 24 HRS. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u> | 11. BIRTHPLACE (City and state or country) <u>Neosho, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
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| 13a. FATHER'S NAME <u>Simpson Atchinson Plummer</u> | 13b. MOTHER'S MAIDEN NAME <u>Mary Dew</u> | 14. NAME OF HUSBAND OR WIFE <u>Wife, Lovie Plummer</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> | 16. SOCIAL SECURITY NO. <u>None</u> | 17. INFORMANT <u>VA Hospital records</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis, Pulmonary, chronic, far advanced, active</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | <u>602 X</u> |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Nephritis, chronic with anuria</u> | | 19. WAS AUTOPSY PERFORMED? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/> |
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| 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.) <u>---</u> |
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|---|---|--|--|----------------------|---------------------|
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a.m. _____ p.m. _____ | 20d. INJURY OCCURRED WHILE AT <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.) <u>---</u> | 20f. CITY, TOWN, OR LOCATION <u>---</u> | COUNTY <u>---</u> | STATE <u>---</u> |
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| 21. Attended the deceased from <u>8-22-56</u> to <u>11-15-57</u> and last saw <u>him</u> alive on <u>11-15-57</u> Death occurred at <u>6:31 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated. | |
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| 22a. SIGNATURE <u>S. C. STROFF, M. D.</u> | 22b. ADDRESS <u>Excelsior Springs, Mo.</u> | 22c. DATE SIGNED <u>11-15-57</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>11-16-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u> | 23d. LOCATION (City, town, or county) <u>Anderson, Missouri</u> | (State) <u>---</u> |
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| 24. FUNERAL DIRECTOR <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u> | 25. DATE RECD. BY LOCAL REG. <u>11-26-57</u> | 26. REGISTRAR'S SIGNATURE <u>Caroline Stuchling</u> |
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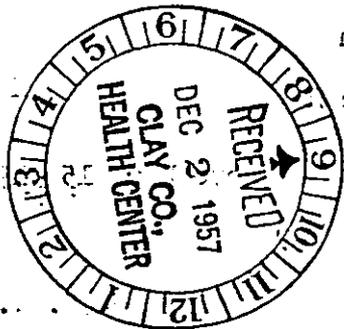
Embalmer's Statement on Reverse Side

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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 Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Lindell Jarman*

Licensed Embalmer No. *1589*
Ernest Springs, 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.