

FILED DEC 30 1957

STANDARD CERTIFICATE OF DEATH

43409

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 298

1. PLACE OF DEATH a. COUNTY Audrain		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Audrain	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico		c. CITY OR TOWN Mexico <u>0043</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Audrain Hospital		d. STREET ADDRESS 915 W. Latney	
3. NAME OF DECEASED (Type or print) First Joseph Middle Benjamin Last Plybon		4. DATE OF DEATH Month Dec. Day 17 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1860
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR Plumbing	11. BIRTHPLACE (City and state or country) Virginia
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Laura Plybon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 500-16-8545	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic degenerative myocarditis with cardiac failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Generalized Arteriosclerosis - and Sclerosis DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 4221	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 11-26-57 to 12-17-57 and last saw ^{her} alive on 12-17-57		22. SIGNATURE (Degree or title) Mary F. O'Brien M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-19-1957	23c. NAME OF CEMETERY OR CREMATORY Elmwood
24. FUNERAL DIRECTOR Precht-Houston		25. DATE RECD. BY LOCAL REG. Dec. 18-1957	26. REGISTRAR'S SIGNATURE Blanche Neely

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.

