

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034997  
STATE FILE NUMBER

FILED SEP 29 1958

Registration District No. 317 Primary Registration District No. 546 Registrar's No. 2367

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Overland City</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Florissant 4000</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF DECEASED (If not in hospital or institution) <b>Lackland Nursing Home</b>		Length of stay in lb <b>5-mon.</b>	d. STREET ADDRESS (If outside, give location) <b>2390 Stirrup Drive</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Plummer</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>11</b> Year <b>1958</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1886</b>	9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>Patrick J. McGrieby</b>		13b. MOTHER'S MAIDEN NAME <b>Mary B. Higgins</b>		14. NAME OF HUSBAND OR WIFE <b>Edward S. Plummer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. G. A. Fallert, 2390 Stirrup Dr.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart Dis.</b>					10 gm.
DUE TO (c) <b>4200</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertensive heart dis.</b>					19. WAS AUTOPSY PERFORMED? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.)			
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.)	20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from <b>1956</b> to <b>9-11-58</b> and last saw her alive on <b>9-10-58</b> Death occurred at <b>7:15 pm.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>W. J. Kuster, M.D.</b>			22b. ADDRESS <b>634 W. Grand</b>		22c. DATE SIGNED <b>9-12-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Sept. 13, 1958</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>
24. FUNERAL DIRECTOR <b>Arthur J. Donnelly</b>		ADDRESS <b>3840 Lindell Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>9-12-58</b>	26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke M.D.</b>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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  .....

Licensed Embalmer No. 4699 .....

P. O. Address 3870 Linnell .....

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.