

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046165

STATE FILE NUMBER
12746

FILED JAN 12 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

S. 300
1-57

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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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ill. b. COUNTY Williamson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	528 CITY OR TOWN Marion Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b 3 wks	d. STREET ADDRESS (If outside, give location) 32 RFD 4 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last OMA OLEVIA PLOUGH			4. DATE OF DEATH Month Day Year DECEMBER 31, 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20 1899
9a. USUAL OCCUPATION (Give kind of work done during the week ending 10 days before death, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years, months, days) 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11a. FATHER'S NAME Josiah Hopper		11b. MOTHER'S MAIDEN NAME Minnie Lawrence	11. BIRTHPLACE (City and state or country) Dexter, Mo
12a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If No give war or dates of service) No		12b. SOCIAL SECURITY NO. No	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Josiah Hopper		13b. MOTHER'S MAIDEN NAME Minnie Lawrence	14. NAME OF HUSBAND OR WIFE Henry Plough
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If No give war or dates of service) No		16. SOCIAL SECURITY NO. No	17. INFORMANT Virginia Davis Ferguson Mo. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION			INTERVAL BETWEEN ONSET AND DEATH 3-4 WEEKS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 420.0			YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from DEC. 8, 1958 to DEC. 31, 1958 and last saw her alive on DEC. 31, 1958 Death occurred at 10:05 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE C. D. Vermillion, M.D. (Degree or title) M. D.		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/1/59
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE Jan 2-59	23c. NAME OF CEMETERY OR CREMATORY Maplewood	23d. LOCATION (City, town, or county) (State) Marion Ill.
24. FUNERAL DIRECTOR Mitchell Funeral Home ADDRESS Marion Ill.		25. DATE RECD. BY LOCAL REG. JAN 2 '59	26. REGISTRAR'S SIGNATURE J. Earl Smith MD (H-T.)

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 *Kenn Proloff*

Licensed Embalmer No. *4356*
P. O. Address *St. Paul, Minn.*

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.