

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

~~21176~~

21077

File No. _____
Registered No. **5928**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. **791**
Township _____ Primary Registration District No. **7003**
City **St. Louis** No. **Barnes Hospital**

2. FULL NAME

Marie Plucinski
(a) Residence. No. **3424 Cherokee** **16** Ward. (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Frank Plucinski**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Nov. 3, 1894**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
33 7 15

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work **Cit. Home**
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo.**

10. NAME OF FATHER **Fred Fischer**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Germany**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Winnifred**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY) **Mo.**

14. INFORMANT **Frank Plucinski**
(Address) **3424 Cherokee Str**

15. FILED **19 1935** **May C. Starling**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **June 17 1930**

17. I HEREBY CERTIFY, That I attended deceased from **6-11** 19**30** to **6-17** 19**30**, and that I last saw her alive on **6-17** 19**30**, and that death occurred, on the date stated above, at **6:05** p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

gaundice - obstructive - cause unknown
127D

CONTRIBUTORY (SECONDARY) **124D**
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? **no** DATE OF _____

WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical**
(Signed) **J. Kenneth Lewis** M. D.

. 19 (Address) **600 So Kingshighway**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Black Jack, Mo** DATE OF BURIAL **June 20 1930**

20. UNDERTAKER **Math. Hermann** ADDRESS **216 E. Fair Ln**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

