No. 2
9-4-41
5-17-39
X29484

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39711

FILED JAN 5 1945

Registrar's District No. 318

Primary Registration District No. 1003

Registrar's No. 11261

1. PLACE OF DEATH:

(a) County: St.

(b) City or town: St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Lukes Hosp.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks (Specify whether years, months or days)

In this community 11

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Mo.

(c) City or town: St. Louis
(If outside city or town limits, write "RURAL") 19

(d) Street No. 4001 Washington Ave.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Sophia Ella Plant

3. (b) If veteran, name war: None

3. (c) Social Security No. None

4. Sex: Female 1

5. Color or race: White

6. (a) Single, widowed, married, divorced: 1

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: March 27, 1861 (Month) (Day) (Year)

8. AGE: Years 83 | Months 9 | Days 1 | If less than one day: hr. min.

9. Birthplace: Ind. 1
(City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: Dr. John T. Doneghy

13. Birthplace: Unknown
(City, town, or county) (State or foreign country)

14. Maiden name: Almeda Burton

15. Birthplace: Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant: Lucille Plant

(b) Address: 4001 Washington Ave. St. Louis

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 30, 1944 (Month) (Day) (Year)

(c) Place: burial or cremation: Belleffountain Cem.

18. (a) Signature of funeral director: Jay B. Smith

(b) Address: 7456 Manchester Ave. Maplewood

19. (a) DEC 29 1944 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28 year 1944 hour 5:45 P.M. minute M.

21. I hereby certify that I attended the deceased from Dec 9 - 1944, 1944, to Dec 28, 1944 that I last saw her alive on Dec 28, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral arteriosclerosis	?
Myocarditis chr.	?
~~Due to~~ Bronchial Asthma	10 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: No op.
Of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work: (e) Means of injury:

23. Signature: J. R. Vaughan (M. D. ~~Another~~)

Address: 634 No. Grand Date signed: 12-29-44

(Licensed Embalmer's Statement on Reverse Side)

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 3454

....., Registered Apprentice No.....

working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address 745 Manchester

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—5-43
I X36930

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 318 Primary Registration District No. 1002 Registrar's No. 11201

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sophie E. Plant

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Mar. 27 1866
(Month) (Day) (Year)

8. AGE: Years 83 Months 9 Days If less than one day hr. min.

9. Birthplace (City, town, or county) Ind (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 8
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

39711