

FILED APR 1 1949

VISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10526

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State File No. ....

2616

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY-REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY <i>San</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis MO.		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis <i>17</i>	
		d. STREET ADDRESS (If rural, give location) II05A N. Sarah St. <i>0</i>	

3. NAME OF DECEASED (Type or Print) a. (First) Clarence b. (Middle) Horice c. (Last) Plummer			4. DATE OF DEATH (Month) (Day) (Year) 3 20 49.		
5. SEX M. <i>2</i>		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married <i>II</i>	
8. DATE OF BIRTH 2-7-1889		9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Austin Tex. <i>1</i>	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Tom Plummer		13b. MOTHER'S MAIDEN NAME Lilly Collins		14. NAME OF HUSBAND OR WIFE Ida M. Plummer	
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. 488-10-2050		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Ida M. Plummer II05 A. N. Sarah St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis, Far Advanced		DUE TO (b) Undetermined <i>1/2</i>			Undet.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) None <i>0021</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2-14, 1949, to 3-20, 1949, that I last saw the deceased alive on 3-20, 1949, and that death occurred at 9:50 a.m., from the causes and on the date stated above.

23a. SIGNATURE Oscar J. Daniels (Degree or title) M. D. <i>(1)</i>		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 3-23-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/26/49.		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
				24d. LOCATION (City, town, or county) (State) St. Louis Mo.	

DATE REC'D BY LOCAL REG. MAR 23 1949		REGISTRAR'S SIGNATURE J. A. Laster		GENERAL DIRECTOR'S SIGNATURE ADDRESS Raymond S. Dozier 4453 Garfield Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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**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.

Signed.....

*James A. Fall*  
*4441*

Licensed Embalmer No. ....

P. O. Address *28299 Washington*

Signed.....  
Student Embalmer

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