

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 28 1949

State File No. 18159

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1078

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

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Dent 33	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Normandy		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Salem	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION O'Sullivan Nursing Home.		d. STREET ADDRESS (If rural, give location) /	

3. NAME OF DECEASED (Type or Print)	a. (First) Everett	b. (Middle) Lafayette	c. (Last) Plank	4. DATE OF DEATH (Month) (Day) (Year) 4 30 1949
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 24, 1882	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Conductor	10b. KIND OF BUSINESS OR INDUSTRY Public Service	11. BIRTHPLACE (State or foreign country) Salem, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME George Plank	13b. MOTHER'S MAIDEN NAME Nancy Blackwell	14. NAME OF HUSBAND OR WIFE Della Plank
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Fern Wagner	ADDRESS 1030 Leona Ave.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 year
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhages		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive & Arteriosclerotic Cardiovascular renal dis DUE TO (c) Paraplegia		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 331X	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 19, 1948**, to **April 30, 1949**, that I last saw the deceased alive on **April 25, 1949**, and that death occurred at **6:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lewis Littman M.D.	23b. ADDRESS 8231 Clayton Rd 17	23c. DATE SIGNED 5/2/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-3-49	24c. NAME OF CEMETERY OR CREMATORY City	24d. LOCATION (City, town, or county) (State) Salem, Mo.
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DATE REC'D BY LOCAL REG. 5-2-49	REGISTRAR'S SIGNATURE Shirley L. ...	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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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.

Student
Student Embalmer

Signed Clement McNeary

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.