V.S. No. 300
REV. 10.48

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14879

State File No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3446

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Missouri Baptist Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MO
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2164
d. STREET ADDRESS (If rural, give location): 4135 Chippiwa 0

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle):
c. (Last): Plisich

4. DATE OF DEATH (Month): 4 (Day): 12 (Year): 50

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: 9-8-1886
9. AGE (In years last birthday): 63 — If under 1 year: Months 7, Days 4 — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Jugoslavia 8
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Frank Plisich
13b. MOTHER'S MAIDEN NAME: Antonie Knez
14. NAME OF HUSBAND OR WIFE: Louise Plisich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Louise Plisich — ADDRESS: 4135 Chippiwa

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) none
DUE TO (c) none

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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): 4222
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 20, 1950, *to* April 12, 1950, *that I last saw the deceased alive on* April 12, 1950, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward A. Snyder MD (Degree or title)
23b. ADDRESS: 705 Olive St
23c. DATE SIGNED: 4-14-50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 0
24b. DATE: 4-15-50
24c. NAME OF CEMETERY OR CREMATORY: Resurrection
24d. LOCATION (City, town, or county): St. Louis (State): Mo

DATE REC'D BY LOCAL REG. APR 14 1950
REGISTRAR'S SIGNATURE: J. B. Lancaster
25. FUNERAL DIRECTOR'S SIGNATURE: Mogdell Funeral Home — ADDRESS: 1936 Allen

(Licensed Embalmer's Statement on Reverse Side)

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

431

705 Olive St
Fri 2-5

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 me

..... Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Dale A. Stearman

Licensed Embalmer No. 4533

P. O. Address 1926 Allen

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.