No. 300
10.48

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

FILED JUN 17 1950
#111352

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21918

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1985

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
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) St. Louis City Hospital #1.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St Louis
d. STREET ADDRESS (If rural, give location) 2208 Dodier 2209 0

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle)
c. (Last) PLUCINSKI

4. DATE OF DEATH (Month) (Day) (Year) June 4th, 1950

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 1-4-1907
9. AGE (In years last birthday) 43 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ashley Ill.
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Roman Plucinski
13b. MOTHER'S MAIDEN NAME Johanna Jankowski
14. NAME OF HUSBAND OR WIFE Blanche Mazur

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. 492-05-0742
17. INFORMANT'S SIGNATURE OR NAME Blanche Plucinski
ADDRESS 2208 Dodier

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) Pulmonary Tuberculosis - Moderate — INTERVAL BETWEEN ONSET AND DEATH: approx 8 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

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 ☐ 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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 082X

22. I hereby certify that I attended the deceased from 5/10/50, 19___, to 6/4/50, 19___, that I last saw the deceased alive on 6/4/50, 19___, and that death occurred at 1:00am m., from the causes and on the date stated above.

23a. SIGNATURE James A. Hutchinson M.D.
(Degree or title)
23b. ADDRESS 1515 Lafayette Ave.,
23c. DATE SIGNED 6/5/50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-7-50
24c. NAME OF CEMETERY OR CREMATORY Calvary
24d. LOCATION (City, town, or county) St Louis Mo. **(State)**

DATE REC'D BY LOCAL REG. JUN 6 1950
REGISTRAR'S SIGNATURE J. B. Fasalen
25. FUNERAL DIRECTOR'S SIGNATURE St Louis Funeral Home
ADDRESS 2205 St Louis Ave.
(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~~ Me

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Elton R. Remelius

Signed.....
Student Embalmer

Licensed Embalmer No. 4283

P. O. Address St. Louis, Mo

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.