

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28980**
Registrar's No. **6895**

FILED SEP 6 1956

BIRTH NO. **65488-56** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

I. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		e. STREET ADDRESS 3891 Delmar	f. (If rural, give location) 21990	
3. NAME OF DECEASED (Type or Print)		a. (First)	b. (Middle)	c. (Last)
Plam		Plam	Plam	Plam
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH July 17 1956	9. AGE (In years last birthday) 13 10. IF UNDER 1 YEAR (Months) 0 11. IF UNDER 24 HRS. (Days) 13 12. IF UNDER 4 HRS. (Min.) 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Thomas Plam		13b. MOTHER'S MAIDEN NAME Minnie Lee Britts		14. NAME OF HUSBAND OR WIFE —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Minnie Lee Plam	
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) gestation in-		DUPLICATE compatible with life		13 hrs.
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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) 776x	
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?	
22. I hereby certify that I attended the deceased from July 17, 1956, to July 18, 1956, that I last saw the deceased alive on July 18, 1956, and that death occurred at 7:00 A.M., from the causes and on the date stated above.				
23a. SIGNATURE Norman K. Merchaux M.D.		23b. ADDRESS 6305 Kings Highway		23c. DATE SIGNED 7-19-56
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-31-56	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. JUL 25 1956		REGISTRAR'S SIGNATURE Earl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Mo Rawland-Aker
				ADDRESS 4104 Manchester

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.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.