

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-009268**

FILED **VS. MAR 3 1960** 317 Primary Registration District No. 547 Registrar's No. 500

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>St. Louis County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Richmond Heights, Mo.</b>		Length of stay in 1b <b>DAYS</b>	c. CITY OR TOWN <b>St. Louis 31, Missouri</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Mary's Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>11109 Conway Road</b>

3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>H.</b> Last <b>Plumpe</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>30</b> Year <b>1960</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-76</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>unk.</b>	12. CITIZEN OF WHAT COUNTRY <b>unk.</b>
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13a. FATHER'S NAME <b>unk.</b>	13b. MOTHER'S MAIDEN NAME <b>unk.</b>	14. NAME OF HUSBAND OR WIFE <b>Lucy Oliver Plumpe</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unk.</b>	16. SOCIAL SECURITY NO. <b>unk.</b>	INFORMANT <b>Medical Record</b>	Address <b>St. Mary's Hospital 6420 Clayton Rd</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b>		<b>1 week</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Generalized Atherosclerosis</b>	<b>5 years.</b>
	DUE TO (c) <b>Uremia</b>	<b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from **1-26-60** to **1-31-60** and last saw <sup>her</sup>him alive on **1-31-60**.  
Death occurred at **1:15 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Martin G. Austin MD</b>	22b. ADDRESS <b>634 W Grand Blvd</b>	22c. DATE SIGNED <b>1-2-60</b>
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23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Anatomical</b>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical</b>	23d. LOCATION (City, town or county) (State) <b>St. Louis MO.</b>
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24. FUNERAL DIRECTOR <b>and-Aker Mortuary Service</b> 1104 Manchester Ave. St. Louis 10, Mo.	25. DATE RECD. BY LOCAL REG. <b>2-15-60</b>	26. REGISTRAR'S SIGNATURE <b>[Signature]</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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.