

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 5 1960

318

1003

7549

-60-028707

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4475 West Pine</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>EUGENE</u>	First	Middle	Last	4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>
--	-------	--------	------	--

5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1882</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
--------------------	-------------------------------	---	---------------------------------------	----------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Architect</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>for F.H.A.</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
--	---	--	---

13a. FATHER'S NAME <u>Henry Pleitsch</u>	13b. MOTHER'S MAIDEN NAME <u>Chara Withey</u>	14. NAME OF HUSBAND OR WIFE <u>Henri Gwinn Pleitsch</u>
--	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Mr. Earl Pleitsch 10554 Halls Ferry Rd.</u>	Address
--	-------------------------------------	--	---------

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) <u>Post-operative shock following transurethral resection for hyperplasia of the prostate on July 28, 1960</u>		<u>one day</u>
DUE TO (b) _____		
DUE TO (c) <u>610X</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Generalized arteriosclerosis</u>	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 checked="" 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.)
--	---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	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
---	--	--	------------------------------	--------	-------

21. I attended the deceased from <u>October 1948</u> to <u>present</u> and last saw <u>him</u> alive on <u>7-29-60</u> Death occurred at <u>11:50 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>Robert C. Kingsland MD</u> (Degree or title)	22b. ADDRESS <u>14 Forsyth Walk, Clayton 5, Mo.</u>	22c. DATE SIGNED <u>7-29-60</u>
--	---	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>August 1, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri.</u>
--	---------------------------------	--	---

24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons</u>	ADDRESS <u>7233 Delmar Bly'd.</u>	25. DATE RECD. BY LOCAL REG. <u>JUL 29 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>
--	-----------------------------------	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*OK*  
*J. K. M. Lewis*  
*signature*  
*8-1-60*

*mjb*

Dr. Robert Kingsland  
14 Forney Dr. Wake,  
2<sup>nd</sup> - 2<sup>30</sup> today 7-29-60  
Pleatrick

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Clarence F. Mc

Licensed Embalmer No. 4077

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.