

S JAN 16 1961
AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 130 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>8 yrs. 9 mo.</u>		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>Chronic Hosp.</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>724a Clara Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Louise</u> Last <u>Ploeger</u>				4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>61</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-74</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Christian Ploeger</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret ?</u>			14. NAME OF HUSBAND OR WIFE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Chronic Hospital Records</u>					Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>8 1/2 yrs.</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>420.0</u>								
		DUE TO (c) <u>Generalized Arteriosclerosis</u>						<u>8 1/2 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Terminal Bronchopneumonia - 5 days.</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)						
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>4-3-52</u> to <u>1-2-61</u> and last saw her alive on <u>1-2-61</u>				Death occurred at <u>9:35 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <u>John W. Beckham M.D.</u>				22b. ADDRESS <u>5800 Arsenal</u>				22c. DATE SIGNED <u>1/3/61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE <u>1-6-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>					
24. FUNERAL DIRECTOR <u>Frank O'Donnell</u>			ADDRESS <u>5600 Arsenal St.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 5 1961</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

DATE AMENDED

INSTEAD OF DOCUMENT

ITEM NO. SHOULD READ

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.

NOT EMBALMED CREMATED BY CITY.

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.