

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043250

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 242

DO NOT WRITE ON THIS STUB

AMENDED

FILED NOV 22 1963

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North Kansas City</u> Length of stay in 1b <u>12 days</u>		c. CITY OR TOWN <u>Excelsior Springs</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1351 N. Jesse James Rd.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>North Kansas City Memorial</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		4. DATE OF DEATH <u>11-19-63</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES HAROLD PLUMMER</u>		5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</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>2-10-91</u> 9. AGE (last birthday) <u>72</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (City and state or country) <u>BRUCE, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>WILLIAM RUSH PLUMMER</u>		13b. MOTHER'S MAIDEN NAME <u>PEARL P. MADDUX</u>	
14. NAME OF HUSBAND OR WIFE <u>EFFIE PLUMMER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>[redacted]</u>		17. INFORMANT <u>EFFIE PLUMMER, EX. SPGS, MO</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>Carcinoma of the stomach</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6-12 mo</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Alcohol</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 checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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>11-6-63</u> to <u>11-19-63</u> and last saw him alive on <u>11-19-63</u> Death occurred at <u>9 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Robert H. Hodge, M.D.</u>		22b. ADDRESS <u>North Kansas City Mo</u>	
22c. DATE SIGNED <u>11-19-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>NOV. 19/63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CROWN HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs Mo</u>	
24. FUNERAL DIRECTOR <u>HOPE FUNERAL HOME EXSPGS</u>		25. DATE RECD. BY LOCAL REG. <u>11-19-63</u>	
26. REGISTRAR'S SIGNATURE <u>Marguerite Hudgens</u>			

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 6004

2 6000

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12 6-0

13 20

USE BLACK INK OR TYPEWRITER RIBBON

Robert H. Hodge, M.D.

MAR 5 1964

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

Chas Virgil Hope

Licensed Embalmer No. 3950

P. O. Address

Excelsior Spring 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.