

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

SEP 14 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28051

Registrar's No. 7551

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____ of St. Louis
 (b) City or town _____
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Missouri Pacific Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Mo. 23 days
 (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME Raymond W^m Polk

3. (b) If veteran, name war _____ No _____ 3. (c) Social Security No. 702-49-4190

4. Sex M 5. Color or race W 6. (a) Single, widowed, divorced, married

6. (b) Name of husband or wife Ruby 6. (c) Age of husband or wife if alive 47 years

7. Birth date of deceased Nov. 10 1886 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	52	9	20	hr. _____ min.

9. Birthplace Coffeyville, Kansas (City, town, or county) (State or foreign country)

10. Usual occupation Telegrapher

11. Industry or business Mo. Pac. R. R.

12. Name Thos. L. Polk

18. Birthplace Indiana (City, town, or county) (State or foreign country)

14. Maiden name Manda Cackrell

15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ruby M. Polk

(b) Address Sedan, Kansas

17. (a) Removal (b) Date thereof 8/31/39 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sedan, Kansas

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette Ave

19. (a) AUG 31 1939 (b) J. B. Budeck (Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Kansas (b) County _____
 (c) City or town Sedan (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30 year 1939 hour 4:00 clock P. M.

21. I hereby certify that I attended the deceased from July 17, 1939, to Aug 30, 1939; that I last saw him alive on Aug 30, 1939; and that death occurred on the date and hour stated above.

Immediate cause of death: Broncho-Pneumonia 2 days
 Carcinomatous 2 mos
 Primary site Pancreas
 My pericarditis 6 mo

Due to _____
 Other conditions: 4/10 (Include pregnancy within 3 months of death)

Major findings: Of operations Metastatic tumor of right seventh rib. Of autopsy _____

Duration
 2 days
 2 mos
 6 mo
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature A. W. Thompson (M. D. or other) Address Missouri People Hosp. Date signed 8/30/39

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Paul A. Keith

Licensed Embalmer No. 3612

P. O. Address 2317 Lafayette

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 this body is not embalmed, above space should be left blank.