

Registration District No. 85 Primary Registration District No. 1001

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

1. PLACE OF DEATH:  
(a) County Buchanan  
(b) City or town St. Joseph  
(c) Name of hospital or institution: St. Joseph's Hospital  
(d) Length of stay: In hospital or institution 18 da.  
In this community 19 Years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Buchanan  
(c) City or town St. Joseph  
(d) Street No. 12 14 S. 11th.  
(e) If foreign born, how long in U. S. A. ? years.

3. (a) PRINT FULL NAME ANNA POLLAK  
3. (b) If veteran, name war none  
3. (c) Social Security No. none

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Morris Pollak 6. (c) Age of husband or wife if alive 71 years  
7. Birth date of deceased Unknown

8. AGE: Years Months Days If less than one day  
Est. 63 hr. min.

9. Birthplace unknown Poland  
(City, town, or county) (State or foreign country)

10. Usual occupation clerk  
11. Industry or business Grocery Store

12. Name Unknown Grinspan  
13. Birthplace Unknown Poland  
14. Maiden name Estner  
15. Birthplace Unknown Poland

16. (a) Informant Mrs. Ethel Kranitz  
(b) Address 5 1/2 Water St. Liberty, Mo.

17. (a) Burial (b) Date thereof 1-2-41  
(c) Place: burial or cremation Shaare Sholem

18. (a) Signature of funeral director FLEEMAN & SON, INC.  
(b) Address St. Joseph, Mo.

19. (a) Jan 2, 1941 (b) Nestlebusch  
(c) Date received local registrar (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Jan. day 1st.  
year 1941 hour 4 minute 15 P.M.

21. I hereby certify that I attended the deceased from 1939 to Jan 1, 1941  
that I last saw her alive on Jan 1, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death: Hypertensive Cardiovascular Renal Disease

Due to Chronic Nephritis  
Due to 5 da

Other conditions: Diabetes Mellitus  
Cancer of Bladder  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations  
Of autopsy

Duration  
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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

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

23. Signature J. H. [Signature] (M. D. or other)  
Address 620 [Address] ST. JOSEPH Date signed 1-2-41

**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.....

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.)**

Body Not Embaled

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