S. No. 2
—1-4-41
5-17-39
P1 X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1942

Registration District No. 2281

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

31116

State File No.

Primary Registration District No. 5968

Registrar's No.

84 0 0

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Rural North Benton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Polk

(c) City or town Rural
(If outside city or town limits, write "RURAL")

(d) Street No. Buffalo Mo
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Francis L. Polly

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife James A.

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Aug (Month) 16 (Day) 1863 (Year)

8. AGE: Years 79 Months Days 27 If less than one day hr. min.

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

10. Usual occupation House Keeper

11. Industry or business

FATHER
12. Name John Camel
13. Birthplace (City, town, or county) Unknown (State or foreign country) 9

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country) 9

16. (a) Informant Luther Polly
(b) Address Buffalo Mo.

17. (a) ~~Reynolds~~ Burial (Burial, cremation, or removal) (b) Date thereof 9-14-1942 (Month) (Day) (Year)
(c) Place: burial or cremation Reynolds Chapel

18. (a) Signature of funeral director L. B. Jones
(b) Address Buffalo Mo.

19. (a) 9/26/42 (Date received local registrar) (b) A. E. Westfall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 13 year 1942 hour 12 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9-18-42 9-11 1942 to 1 visit 19 ; that I last saw h. alive on 9-10 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations nnn

Of autopsy nnn

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 9-13-42

(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? (Specify type of place)

While at work? (e) Means of injury

23. Signature V. H. Greenwood (M. D. or other)

Address 9-26-42 Date signed

1236 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7
District File Number 10-42-1030
Date Filed 10-2-42

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 the above constitutes grounds for revocation of license.)

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

. S. No. 2B
0M—8-7-1-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31116

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

1. PLACE OF DEATH:

(a) County: Polk

(b) City or town: Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State ..... (b) County .....

(c) City or town .....
(If outside city or town limits, write "RURAL")

(d) Street No. .....
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Francis L. Polly

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife .....

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Aug (Month) 16 (Day) 1863 (Year)

8. AGE: Years 79 | Months | Days | If less than one day: ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

13. Birthplace: (City, town, or county) ..... (State or foreign country) .....

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) ..... (Date received local registrar) (b) K. E. Westfall (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 13 year 1942 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of the bowels

Due to .....

Due to .....

Other conditions (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? ..... (City or town) (County) (State)

(b) 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 ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY