

NOV 1 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4433

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
3516 Forest Avenue
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 50 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 3516 Forest Avenue
(If rural, give location)

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

3. (a) PRINT FULL NAME Mr. Mitchell C. Polfer

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 16th
year 1943 hour 12 minute 30 P. M.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mrs. Flora I. Polfer

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

7. Birth date of deceased: July 22 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 3-10-43 to 10-16-43

that I last saw him alive on 10-16-43 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days 74 2 24
25
If less than one day hr. min.

Immediate cause of death: Cerebral Hemorrhage - The 20th + third Oct 1943

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

Due to Blood Pressure 224

Due to _____

10. Usual occupation Merchant - Retired

Other conditions (Include pregnancy within 3 months of death) Nephritis

11. Industry or business Grocery Business

Major findings: None

Of operations: None

Of autopsy: None

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name Nicholas Polfer

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

14. Maiden name Margaret Argo

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

16. (a) Informant Robert Lewis

(b) Address 3516 Forest

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

(a) Accident, suicide, or homicide (specify) None

(b) Date of occurrence None

(c) Where did injury occur? None
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? None

17. (a) Burial Brookings Cemetery
(Burial, cremation, or removal) (b) Date thereof Oct. 19, 1943
(Month) (Day) (Year)

(c) Place: burial of Brookings Cemetery

(e) Signature of funeral director O. H. Newcomer's Sons
(Specify type of place)

(f) Means of injury None

23. Signatures W. E. Brown (M. D. or other) None
Date signed

18. (a) Signature of funeral director O. H. Newcomer's Sons

(b) Address 1401 Brush Creek Blvd.

19. (a) 10-19-43 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

Address 114 Bryant Bldg Date signed 10-18-43

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

No. 2
7-39
X35697

W. Eugene Calhoun
714 Boulevard
2. 5: 36

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 E. M. Calhoun

Licensed Embalmer No. 3506

P. O. Address KC 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 this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33913
Registrar's No. 4403

Registration District No. 149 Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kennett city
(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

In this community
years, months or days)

3. (a) PRINT FULL NAME Mitchell C. Palfer

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 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 July 22 1943
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 2 Unless than one day _____ min.

9. Birthplace Kennett, Mo. (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 _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 1 Year 1943 hour _____ minute _____ M.

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

Immediate cause of death Cerebral hemorrhage of the left occipital lobe

Due to Blood pressure 224

Due to hypertension

Chronic interstitial Nephritis

Other conditions 13.10.44
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 131a

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 Eugene Carbaugh (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

33913