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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 24 1944

State File No. _____

Registration District No. 42

Primary Registration District No. 1800

Registrar's No. 152

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: Mo. Methodist Hospital
(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 40 years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. R.R.#5.
(If rural, give location)

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

3. (a) PRINT FULL NAME Charlie Pollard

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Grace Pollard 6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased Dec. 31 1890
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

53	1	5	hr. _____ min.
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9. Birthplace Colwell County, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Alex Lawson Pollard

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

14. Maiden name Martha C. Morgan

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

16. (a) Informant Mrs. Grace Pollard

(b) Address R.R.#5.

17. (a) Burial (b) Date thereof 2 9 '44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy, Kansas.

18. (a) Signature of funeral director Herman W. Sidenfaden

(b) Address 1802 Union St.

19. (a) 2-9-44 (b) Alse Herzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 6
year 1944 hour 1 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan. 25, 1944, to Feb. 6, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Right subpharyngeal abscess

Due to Gen. peritonitis

Due to Ruptured gangrenous appendix

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

Major findings: Of operations Same

Of autopsy X

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 0

23. Signature Cabrey Worthington (M. D. or other) MD

Address St. Joseph, Mo. Date signed 2-7-44

Duration

4 days

2 wks.

2 wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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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 *Herman W. Sidenfaden*

Licensed Embalmer No. *13728*

P. O. Address *St. Joseph 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.