

FILED OCT 6 1945

1003

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County \_\_\_\_\_

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

(c) Name of hospital or institution:  
St. Louis City Hospital—Max C. Starkloff  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution newborn Memorial  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County 000

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

Street No. 3718 N Blair  
(If rural, give location)

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

3. (a) PRINT FULL NAME Albert Richard 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 Child

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sep 23 Dr. 1945  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace St. Louis \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Fred Pollard

13. Birthplace MO \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Hilda Schramel

15. Birthplace MO \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Fred Pollard

(b) Address 3718 Blair Ave 1945

17. (a) Burial (b) Date thereof Sep 25 th  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem.

18. (a) Signature of funeral director Edward Koch

(b) Address 3516 14th St

19. (a) SEP 25 1945 (b) J. F. Budeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 24th  
year 1945 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from 9/23/45  
\_\_\_\_\_ 19 \_\_\_\_\_ to 9/24/45 19 \_\_\_\_\_

that I last saw him alive on 9/24/45 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Prematurity Duration \_\_\_\_\_

Due to 6 month gestation

Due to 159

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 M. J. Carson (M. D. or other) \_\_\_\_\_  
Address 1515 Lafayette 9/24/45 Signed \_\_\_\_\_

**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.

**No Embalming**

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.)**

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