

No. 2
-1/47
5-17-39

FILED SEP 8 1947

318

STANDARD CERTIFICATE OF DEATH

1003

State File No. 29409
8282
Registrar's No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Res: 4445 Forest Park Blvd.,
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4445 Forest Park Blvd.,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME JOSEPHINE W. POLK,

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 Widowed
6. (b) Name of husband or wife Samuel Polk, 6. (c) Age of husband or wife if alive Dec'd years
7. Birth date of deceased Aug 28 - 1868
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days 7 If less than one day
hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

12. Name Dr. Matthew Wakefield

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

14. Maiden name Unknown

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

16. (a) Informant Clifford Grebe

(b) Address 314 N. Broadway

17. (a) Removal (b) Date thereof Aug 30/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Joseph, Missouri

18. (a) Signature of funeral director C. R. Lupton & Sons

(b) Address #7233 Delmar Bly'd.

19. (a) AUG 30 1947 (b) J. T. Bredon
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August, day 29th,
year 1947, hour 12:30 minute P. M.

21. I hereby certify that I attended the deceased from Jan 1 1947 to Aug 29 1947
that I last saw her alive on Aug 28 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
Due to Atherosclerosis

Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

Duration
6 years
10 yrs

PHYSICIAN

Underline the cause of 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?.....
(Specify type of place)
While at work?..... (c) Means of injury.....

23. Signature M. E. Jones (M. D. or other)
Address 4050 Delmar St Date signed Aug 29 47

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

MOTHER FATHER

Dr W. E. Jones.
4500 Olive Street,
R0: 2866.
Hrs: 2 - 4.

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 _____

Paul C. K. [unclear], Registered Apprentice No. 4
working under my personal supervision.

Signed _____

Raymond L. Harris

Licensed Embalmer No. 4330

P. O. Address St. Louis, 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.

Sept
8282

Registration District No. *318*

Primary Registration District No. *1003*

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **ST. LOUIS**
(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..... *Josephine W. Palk*

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

4. Sex..... *F* 5. Color or race..... *W*

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

7. Birth date of deceased.....
(Month) (Day) (Year)

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

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

10. Usual occupation.....

11. Industry or business.....

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) *SEP 19 1947*

19. (a) (Date received local registrar) (b) *J. J. Bredek*
(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..... Day.....
 year..... hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
 that I last saw him/her on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Duration

Due to.....

Due to.....

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?
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature..... (M. D. or other)
 Date signed.....

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

SUPPLEMENTAL

MOTHER, FATHER

S-29409