

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37129**
4807

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

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|--------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE Mo b. COUNTY Saline | |
| b. CITY (If outside corporate limits, write RURAL and give township) Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) Slater | |
| c. LENGTH OF STAY (in this place) 3 days | | d. STREET ADDRESS (If rural, give location) 746 N Elm St | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hospital | | | |

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|---------------------------------------------------------------------|---------------------------|-----------------------------|-----------------------------|--------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) Chas Polte (Polte) | a. (First) Chas | b. (Middle) Polte | c. (Last) (Polte) | 4. DATE OF DEATH (Month) (Day) (Year) Nov 11-49 |
|---------------------------------------------------------------------|---------------------------|-----------------------------|-----------------------------|--------------------------------------------------------------|

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|-----------------------|----------------------------------|-------------------------------------------------------------------------|----------------------------------------|----------------------------------------------|---------------------------|---------------------------|-------------------------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Jan 26-1879 | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Hours | IF UNDER 1 HRS. Min. |
|-----------------------|----------------------------------|-------------------------------------------------------------------------|----------------------------------------|----------------------------------------------|---------------------------|---------------------------|-------------------------|

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| 10a. USUAL OCCUPATION (If deceased worked during most of working life, and if retired) Retired Miller | 10b. KIND OF BUSINESS OR INDUSTRY Flour Mill | 11. BIRTHPLACE (State or foreign country) Germany | 12. CITIZEN OF WHAT COUNTRY USA |
|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------|

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|-----------------------------------------|--------------------------------------------------|------------------------------------------------------|
| 13a. FATHER'S NAME Fred Polte | 13b. MOTHER'S MAIDEN NAME Ornit Kevord | 14. NAME OF HUSBAND OR WIFE Mrs Anna Polte |
|-----------------------------------------|--------------------------------------------------|------------------------------------------------------|

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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT'S SIGNATURE OR NAME Carl Polte - Kansas City Mo | ADDRESS Mo |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerosis - Terminal Uremia | | 5 days |
| | ANTECEDENT CAUSES Arterio sclerosis heart disease Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis nephritis DUE TO (c) Generalized Arterio sclerosis | | 1 yr. |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Acute Upper Respiratory Infection | | | Several years |

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| 19a. DATE OF OPERATION No | 19b. MAJOR FINDINGS OF OPERATION 4200 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |
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|------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
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| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------|

22. I hereby certify that I attended the deceased from **11/9/49** to **11/11/49**, that I last saw the deceased alive on **11/11/49**, and that death occurred at **6:35 P.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE Joseph E. Welker M.D. | 23b. ADDRESS 836 Prof. Bldg. K.C. Mo | 23c. DATE SIGNED 11/12/49 |
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|-------------------------------------------|------------------------------|-----------------------------------------------------------------------------|-------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE 11-13-49 | 24c. NAME OF CEMETERY OR CREMATORY Slater City Cemetery Slater Mo | 24d. LOCATION (City, town, or county) (State) Slater Mo |
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|---------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------|---------|
| DATE REC'D BY LOCAL REG. 11-12-49 | REGISTRAR'S SIGNATURE Geraldine Holmes | 25. FUNERAL DIRECTOR'S SIGNATURE Jones & Saffers Slater Mo | ADDRESS |
|---------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------|---------|

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 3 1949

APR 21 1950

JUN 7 1950

OCT 28 1950

OCT 29 1952

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *James E. Jones* _____

Licensed Embalmer No. *3143* _____

P. O. Address *Slater 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.