

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **335**

FILED FEB 6 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **102**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Andrew</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>Amazonia</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>1 day</b>		e. STREET ADDRESS (If rural, give location) <b>0020</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Joseph's Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>IDA</b> b. (Middle) <b>ROSE</b> c. (Last) <b>POLLARD</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>January 26, 1956</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>June 17, 1886</b>
9. AGE (in years, last birthday) <b>69</b>		IF UNDER 1 YEAR Days	IF UNDER 2 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Andrew County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13a. FATHER'S NAME <b>John Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Elise Egger</b>	14. NAME OF HUSBAND OR WIFE <b>J. R. Pollard</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Henry Miller, 5619 S. 4th, St. Joseph, Mo.</b>
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, ashenia, 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) <b>Cardiac Arrest - Bundle Block</b>		<b>3 days</b>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cardiac Hypertrophy</b>		<b>6 mos</b>	
DUE TO (c) <b>Old Rheumatic Heart</b>		<b>5 yrs.</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>4/6x</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 <b>Dec 10, 1955</b> , to <b>Jan 26, 1956</b> , that I last saw the deceased alive on <b>Jan 26, 1956</b> , and that death occurred at <b>5:55 p. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Dr. W. Allison</b> <b>MD</b>		23b. ADDRESS <b>520 Francis St. Joseph, Mo.</b>	23c. DATE SIGNED <b>1-27-56</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>1/30/1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Ashland Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Jan 31, 1956</b>	<b>485</b> <b>Robert M. Allison</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Newton Bowman St. Joseph, Mo.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 21 1921

*W. Cray*

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.....  
Signature of Student Embalmer

Signed *William Spalding*.....

Licensed Embalmer No. *453*

P. O. Address *3195 11th St*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.