

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10189

FILED APR 12 1957

318

1003

STATE FILE NUMBER

2776

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>GRANITE CITY</u> ⁸¹²⁰	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>No. Pac. Hosp. Assn.</u>		Length of stay in lb <u>20 day</u>		d. STREET ADDRESS <u>7260 DELMAR AVE</u> ^(If outside give location)	
3. NAME OF DECEASED (Type or print) First <u>POLLACK</u> Middle _____ Last <u>DUGUID</u>		4. DATE OF DEATH Month <u>MAR.</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 5, 1884</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FRAGMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MYNKLEY BRIDGE</u>		11. BIRTHPLACE (City and state or country) <u>OAK DALE, ILLINOIS</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Myrtle Duguid</u> ^{Address} <u>2260 Delmar Granite City, Ill</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FATTY DEGENERATION of LIVER (TOXIC)</u> <u>PULMONARY EDEMA AND CONGESTION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>POST-OP. CUSTECTOMY and URETH BLADDER</u> <u>with P.O. day for CARCINOMA of URINARY BLADDER</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>1817</u>		
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. _____ p. m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>2-27-57</u> to <u>3-19-57</u> and last saw her alive on <u>3-18-57</u> Death occurred at <u>8:00 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>W. F. Melick M.D.</u>		22b. ADDRESS <u>539 N Grand Ave</u>		22c. DATE SIGNED <u>3/21/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>3/20/1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT HOPE</u>	
24. FUNERAL DIRECTOR <u>Frank Mercer</u>		ADDRESS <u>Granite City, Ill</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 21 '57</u>	
				26. REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

securing the medical certification in the specific manner required by law.

2883

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 *Charles E. Mercer*

Licensed Embalmer No. *298*

P. O. Address *Route City*

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.