

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 1 1957

22194  
STATE FILE NUMBER 146

Registration District No. 294 Primary Registration District No. 3056 Registrar's No. 146

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Held for information attending - 6-17-57

1. PLACE OF DEATH a. COUNTY <b>RANDOLPH</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>RANDOLPH</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>MOBERLY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>MOBERLY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MCCORMICK HOSPITAL</b> Length of stay in 1b <b>2 WKS.</b>		d. STREET ADDRESS (If outside, give location) <b>514 So. WILLIAMS</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>FRANCIS</b> Last <b>POLK</b>			4. DATE OF DEATH <b>JUNE 16, 1957</b> Month <b>JUNE</b> Day <b>16</b> Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 24, 1887</b>
9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>	11. BIRTHPLACE (City and state or country) <b>PATTERSON (WAYNE) MO.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>FRANCIS M. POLK</b>		14. MOTHER'S MAIDEN NAME <b>SARAH LYDA CLINE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>490-09-6274</b>	17. INFORMANT Address <b>MRS. L.F. BARRON, MOBERLY</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Circulatory failure</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>6 weeks</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4200</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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.)
20c. TIME OF INJURY Hour <b>9:15 P.</b> Month <b>June</b> Day <b>16</b> Year <b>1957</b> a. m. <b>p. m.</b>			
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 <b>June 1, 1957</b> to <b>June 16, 1957</b> and last saw her alive on <b>June 16, 1957</b> Death occurred at <b>9:15 P.</b> m on the <b>16</b> day stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>M. C. Easley DO</b>		22b. ADDRESS <b>Huntsville Mo</b>	22c. DATE SIGNED <b>6-18-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>6-19-1957</b>	23c. NAME OF CEMETERY OR CREMATORIUM <b>OAKLAND</b>	23d. LOCATION (City, town, or county) (State) <b>MOBERLY, MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>MAHAN FUNERAL SERVICE</b>		25. DATE RECD. BY LOCAL REG. <b>6-19-57</b>	26. REGISTRAR'S SIGNATURE <b>Leah Lawrence</b>

(Licensed Embalmer's Statement on Reverse Side)

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 *John A. Gues*.....

Licensed Embalmer No. 38

P. O. Address *Proper*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.