

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45332

FILED JAN 2 1958

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 146

V. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY <u>PIKE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOUISIANA</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>LOUISIANA</u> <u>082</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE CO. HOSP</u> Length of stay in lb <u>LIFE</u>		d. STREET ADDRESS (If outside, give location) <u>PLANTERS HOTEL</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TONY MICHAEL POLLAK</u>			4. DATE OF DEATH Month Day Year <u>DEC 15, 1957</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5, 1875</u>
9. AGE (In years last birthday) <u>82</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT CUTTER - BUTCHER SHOP</u>	11. BIRTHPLACE (City and state or country) <u>LOUISIANA, MO.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MEAT CUTTER - BUTCHER SHOP</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13a. FATHER'S NAME <u>JOHN POLLAK</u>		13b. MOTHER'S MAIDEN NAME <u>CHRISTINA KESSLER</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>488-24-8658</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>Coronary Artery Occlusion</u> <u>Complete heart block</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular disease with</u> DUE TO (c) <u>cardiac hypertrophy.</u>		14. NAME OF HUSBAND OR WIFE <u>MISS FLORENCE CHAPMAN, QUINCY, ILL.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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>-----</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. <u>-----</u>		20d. INJURY OCCURRED WHILE AT <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.) <u>-----</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>-----</u>	
21. I attended the deceased from <u>1955</u> to <u>12/15/57</u> and last saw <u>him</u> alive on <u>12/15/57</u> Death occurred at <u>12:18</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Chas. H. Lemellen M.D.</u>		22b. ADDRESS <u>Louisiana, Missouri</u>	
22c. DATE SIGNED <u>12/17/57</u>		22c. DATE SIGNED <u>12/17/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>DEC 17, 1957</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>		23d. LOCATION (City, town, or county) (State) <u>LOUISIANA, MO.</u>	
24. FUNERAL DIRECTOR <u>GEO. M. COLLIER - LOUISIANA, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 24 57</u>	
26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JAN 9 1958

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

Geo. M. Collier

Licensed Embalmer No.

3839

P. O. Address

Louisiana

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.