

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-020073

STATE FILE NUMBER

FILED JUN 1 1959

Registration District No. 323

Primary Registration District No. 4474

Registrar's No. 23

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>SALINE</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>SALINE</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sweet Springs</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>MALTA BEND</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>Forsyth Restorium</u>		Length of stay in 1b <u>15 months</u>	d. STREET (If outside, give location) ADDRESS <u>Not Numbered</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CORA</u> Middle <u>POLLARD</u> Last <u>ROSS</u>			4. DATE OF DEATH Month <u>MAY</u> Day <u>25</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 2, 1879</u>	9. AGE (In years last birthday) <u>80</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>MALTA BEND, MO.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>J. A. POLLARD</u>		13b. MOTHER'S MAIDEN NAME <u>JENNIE FUNK</u>		14. NAME OF HUSBAND OR WIFE <u>-----</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 Address <u>Albert Ross - Malta Bend, Mo.</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>Hypostatic Pneumonia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. DUE TO (b) <u>Cerebrovascular accident</u>					<u>Unknown</u>
DUE TO (c) <u>Cerebral arteriosclerosis</u>					<u>"</u>
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 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.)			
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>Nov 58</u> to <u>5-25-59</u> and last saw her/him alive on <u>5-25-59</u> Death occurred at <u>2:30 pm.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Charles A. Worley, M.D.</u>			22b. ADDRESS <u>Acad Spring Mo.</u>		22c. DATE SIGNED <u>5/25/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>5-27-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Little Grove Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Malta Bend, Mo.</u>
24. FUNERAL DIRECTOR <u>Ampbell-Lewis</u>		ADDRESS <u>MARSHALL, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>May 26, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Maop Manley</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

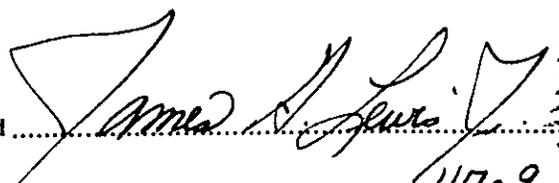
MEDICAL CERTIFICATION

CHARLES A. WORLEY, M.D.

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 

Licensed Embalmer No. ⁴⁷⁰⁹

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