

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023786  
STATE FILE NUMBER

FILED JUN 22 1959 Registration District No. 324 Primary Registration District No. 3073 Registrar's No. 98

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY Saline   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Saline |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN Marshall                   |  | c. CITY OR TOWN Marshall  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION Ritzgibbon hosp. |  | Length of stay in 1b 10 years   |  |
| d. STREET ADDRESS 645 N. English  |  | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  |  |

|   |                           |   |  |  |   |
|---|---------------------------|---|--|--|---|
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br>Lea Morgan Pollard                            |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>June 14th 1959             |  |   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Jan. 17, 1875                                | 9. AGE (In years last birthday)<br>84  | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>House wife |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own home   | 11. BIRTHPLACE (City and state or country)<br>Saline County, Mo. | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |   |

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 13a. FATHER'S NAME<br>James Morgan   |  | 13b. MOTHER'S MAIDEN NAME<br>Emily L. Witcher |  | 14. NAME OF HUSBAND OR WIFE<br>-----               |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>No |  | 16. SOCIAL SECURITY NO.<br>None               |  | 17. INFORMANT<br>Mrs Charles Godman, Marshall, Mo. |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 hrs.</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  | DUE TO (b) <u>Massive Gastric Hemorrhage</u> |  |  |
|   | DUE TO (c) <u>Peptic Ulcer 5400</u>          |  |  |

|   |  |  |   |
|---|--|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Arteriosclerosis Cardiovascular Renal Nerve</u> |  |  | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>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<br>Marshall Mo | COUNTY | STATE |
|--|--|---|--------|-------|

21. I attended the deceased from 10 June 59 to 14 June 59 and last saw her alive on 14 June 59  
Death occurred at 2-30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

|   |                                    |                                       |
|---|------------------------------------|---------------------------------------|
| 22a. SIGNATURE<br><u>E. Lee M. Workle M.D.</u> (Physician or title) | 22b. ADDRESS<br><u>Marshall Mo</u> | 22c. DATE SIGNED<br><u>15 June 59</u> |
|---|------------------------------------|---------------------------------------|

|  |                               |  |  |
|--|-------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u> | 23b. DATE<br><u>6-16-1959</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ridge Park cemetery</u> | 23d. LOCATION (City, town, or county)<br><u>Marshall, Missouri</u> |
|--|-------------------------------|--|--|

|  |   |   |
|--|---|---|
| 24. FUNERAL DIRECTOR<br><u>Campbell-Lewis, Marshall, Mo.</u> | 25. DATE RECD. BY LOCAL REG.<br><u>6-16-'59</u> | 26. REGISTRAR'S SIGNATURE<br><u>Cecil G. Reed</u> |
|--|---|---|

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James H. Lewis Jr.* .....

Licensed Embalmer No. *4788* .....

P. O. Address *Marshall* .....

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.