

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 16 1959

59-042367

2 9491

STATE FILE NUMBER

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 Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b --		c. CITY OR TOWN Ladue, Mo.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 18 St. Andrews Drive		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle M. Last POLK				4. DATE OF DEATH Month October Day 16 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1878	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney			10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (City and state or country) Helena, Ark.		12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME Rufus Polk			13b. MOTHER'S MAIDEN NAME Cynthia Pillow Martin			14. NAME OF HUSBAND OR WIFE Esther Tilton Polk			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Address Wm. L. Polk, 4664 Pershing, St. Louis, Mo.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Cerebral hemorrhage							36 hours		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) General arteriosclerosis									
DUE TO (c) 331x									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
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 _____ s.m. _____ p.m. _____		Month, Day, Year _____							
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 May 11 1954 to Oct 16 '59 and last saw ^{her} him alive on Oct 15 1959 Death occurred at 12³⁰ AM on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Samuel B Grant M.D.				22b. ADDRESS 114 N Taylor Ave				22c. DATE SIGNED 10-16-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct 17, 1959	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri				
24. FUNERAL DIRECTOR C.R. Lupton & Sons, 7233 Delmar				25. DATE RECD. BY LOCAL REG. OCT 16 '59		26. REGISTRAR'S SIGNATURE Carl Smith, M.D. <i>MSB</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Sam's Grant
114 W. Taylor

1:00 PM - 6:00 PM FRI.

CITY WISE

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 Clarence J. Murray

Licensed Embalmer No. 4011

P. O. Address J. Lewis

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.