

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-005253

FILED VS. MAR 7 1960 042

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STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Livingston</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in lb <i>6 weeks</i>		c. CITY OR TOWN <i>Chillicothe</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Chillicothe Nursing Home</i> <i>718 N. 7th St.</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>908 Locust</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Martha</i> Middle <i>Elizabeth</i> Last <i>Polley</i>				4. DATE OF DEATH Month <i>Feb.</i> Day <i>29</i> Year <i>1960</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 9, 1894</i>	9. AGE (last birthday) <i>65</i>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <i>Brimson, Mo.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Martin Duncan</i>			13b. MOTHER'S MAIDEN NAME <i>Matilda Walden</i>			14. NAME OF HUSBAND OR WIFE <i>Guy Polley</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT <i>Loren Boon 3515 Jackson</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i>							INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>	
DUE TO (b) <i>Coronary Heart Disease</i>							<i>unknown</i>	
DUE TO (c) <i>Arteriosclerosis</i>							<i>unknown</i>	
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 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 a.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 <i>2/29/60</i> to <i>2/29/60</i> and last saw <sup>her</sup> alive on <i>2/29/60</i> Death occurred at <i>3:00 a</i> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22. SIGNATURE (Degree or title) <i>Sharon E. Waggoner M.D.</i>				22b. ADDRESS <i>301 Illinois Ave St. Joseph, Missouri</i>		22c. DATE SIGNED <i>3/1/60</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal &amp; Burial</i>		23b. DATE <i>Feb. 29, 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Edinburg Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Edinburg Mo.</i>			
24. FUNERAL DIRECTOR <i>Clark Funeral Home St. Joseph, Mo.</i>			25. DATE RECD. BY LOCAL REG. <i>Mar 3, 1960</i>		26. REGISTRAR'S SIGNATURE <i>Wm Clark Standell</i>			

DOCUMENT

BY AFFIDAVIT OF S. E. Waggoner, M.D. ORIGINAL CERTIFICATION

Dr. Mothershead

**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 *Ernest Clark*

Licensed Embalmer No. 4238

P. O. Address *St. Joseph*

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.