

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040961

FILED VS DEC 15 1960

Registration District No. 11 Primary Registration District No. 5052 Registrar's No. 107 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>BARRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BARRY</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Roaring River TWP.</u> Length of stay in lb <u>8 yrs.</u>		c. CITY OR TOWN <u>Exeter</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) <u>His Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>BYRON</u> Middle <u>L.</u> Last <u>POLLARD</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>2</u> Year <u>1960</u>			
--	--	--	---	--	--	--

5. SEX <u>MALE</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>UNKNOWN</u>	9. AGE (last birthday) <u>LATE SIXTIES</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>
--------------------	-------------------------------	---	---------------------------------	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CARPENTER</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>NEBRASKA U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY
---	-----------------------------------	---	-----------------------------

13a. FATHER'S NAME <u>Don't Know</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE
--------------------------------------	--	-----------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>World War One</u>	16. SOCIAL SECURITY NO. <u>463-07-8834</u>	17. INFORMANT <u>B.D. McQueen - Wheaton - Mo.</u>	Address
---	--	---	---------

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) <u>Congestive Heart Failure</u>		<u>12 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DOE TO (b) <u>Mitral Insufficiency</u>	<u>4 yrs</u>
	DOE TO (c) <u>Arteriosclerotic Heart Disease</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Aneurysm of Abdominal Aorta</u>		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 <u> </u> a.m. <u> </u> 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 <u>5-15-58</u> to <u>12-2-60</u> and last saw her/him alive on <u>12-2-60</u> Death occurred at <u>6:40</u> <u>7</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>H. H. Johnson D.O.</u> (Degree or title)	22b. ADDRESS <u>Cassville Mo</u>	22c. DATE SIGNED <u>12-2-60</u>
--	----------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Dec 5-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Muncy Chappell</u>	23d. LOCATION (City, town, or county) <u>Barry County Missouri</u> (State)
---	-----------------------------	--	--

24. FUNERAL DIRECTOR <u>McQueen Funeral Home, Wheaton Mo</u>	25. PAGE RECD. BY LOCAL REG. <u>12-6-1960</u>	26. REGISTRAR'S SIGNATURE <u>Grease Williams</u>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 15 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Paul D. Herbert

Licensed Embalmer No. 4576

P. O. Address Cassville

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.