MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

8061

PLACE OF DEATH

County Bates

Township ____ or Village ____ or City Butler (NO. ____ E. Chestnut St.; 1st Ward)

Registration District No. 50 File No. [redacted]

Primary Registration District No. 3004 Registered No. 14

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Claud Pollock

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): single

DATE OF BIRTH: Sept (Month) 7 (Day) 1873 (Year)

AGE: 39 yrs. 5 mos. 26 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work: Retired Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 5-03

BIRTHPLACE (City or town; State or foreign country): Marshfield Mo

PARENTS:

NAME OF FATHER: Geo. W Pollock

BIRTHPLACE OF FATHER (City or town, State or foreign country): New York

MAIDEN NAME OF MOTHER: Mollie Vorhuse

BIRTHPLACE OF MOTHER (City or town, State or foreign country): New Jersey

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X Rudolph Pollock

(ADDRESS) Butler Mo.

Filed Mar 3, 1913. T. C. Boulware REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: March (Month) 3 (Day), 1913 (Year)

I HEREBY CERTIFY, that I attended deceased from Mch 3, 1911, to Mch 1st, 1913, that I last saw him alive on Mch 1st, 1913, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A

(Duration) 2 yrs. ___ mos. ___ ds.

Contributory (SECONDARY) Nothing Vast & Mixed

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. C. Crabtree M. D.

Mch 3, 1913 (Address) Butler Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

PLACE OF BURIAL OR REMOVAL: Oak Hill

DATE OF BURIAL: Mar 4, 1913

UNDERTAKER: A H Culon F. Co.

ADDRESS: Butler, Mo.

(Address) ____

19 PLACE OF BURIAL OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL ____, 191__

ADDRESS

PLACE OF DEATH

MISSOURI STATE BOARD OF H
BUREAU OF VITAL STATISTI
CERTIFICATE OF DEATH

County _____

Tow[redacted] _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If deat hospital give its of street

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS		
SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____, *1*_____
(Month) (Day) (Year)

AGE _____ yrs. _____ mos. _____ ds.

If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____
(Month) (D

I HEREBY CERTIFY, that I attended de

_____, 191__, to _____

that I last saw h_____ alive on _____

and that death occurred, on the date stated above,

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mo

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mo.)

(Signed) _____

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violen (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, T RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ m

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BU
UNDERTAKER	ADDRESS

ant neoplasms); *Measles*
ular heart disease; Chron
e contributory (secondar
l not be stated unless im
(disease causing death)
secondary), *10 ds.* Neve
minal conditions, such a
symptomatic), "Atrophy,
lsions," "Debility" ("Con
sy," "Exhaustion," "Hear
nition," "Marasmus," "Ol
"Weakness," etc., when
ined as the cause. Alway
from childbirth or mis
ptichaemia," "PUERPERA
for which surgical operatio
IT DEATHS state MEANS O
ENTAL, SUICIDAL, OR HOMI
if impossible to determin
ental drowning; Struck b
er wound of head—homicide
bably suicide. The natur
ull, and consequences (e. g.
under the head of "Con
ns on statement of cause o
e on Nomenclature of th