

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

Do not use this space.

23990

**1. PLACE OF DEATH**

County Callaway Registration District No. 103-  
Township Superior Primary Registration District No. 515-6  
City (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. 20

**2. FULL NAME**

Margaret Elizabeth Polack  
(a) Residence No. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) \_\_\_\_\_ (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Joseph H. Polack

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan - 23 1882

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
74 | 6 | 0

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Callaway Co.

**10. NAME OF FATHER**

Samuel Martin

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) Not Known  
Virginia

**12. MAIDEN NAME OF MOTHER**

Jane Bridges

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) Not Known  
Virginia

**14.**

INFORMANT Joe W. Smith  
(Address) Portland, Me.

**15.**

FILED 724 1929 W. H. Williams  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7-23 1929

17. I HEREBY CERTIFY That I attended deceased from \_\_\_\_\_  
\_\_\_\_\_ 1929, to \_\_\_\_\_ 1929  
that last saw \_\_\_\_\_ alive on \_\_\_\_\_ 1929, and that death occurred, on the date stated above, at \_\_\_\_\_  
9:15 P. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Valvular Insufficiency  
Cardiatis Endocarditi

CONTRIBUTORY Chromia nephrit.  
(SECONDARY)

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) W. H. Williams, M. D.

, 19 (Address) Mokane Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

Cressant Hill Cemetery 7-23 1929

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

W. H. Williams Mokane Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK

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