

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

Do not use this space.

5658

1. PLACE OF DEATH

County Macon Registration District No. 1000 File No. 5658
 Township Eagle Primary Registration District No. 1000 Registered No. 5658
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Clara Jimima Polliet

(a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED Married to
husband or (OR) WIFE OF A. M. Polliet

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 25' 1864

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____hra. or _____min.
65 | 5 | 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Morroe Co Iowa
 (STATE OR COUNTRY)

10. NAME OF FATHER Samuel Elder

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Ann Anderson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Iud.
 (STATE OR COUNTRY)

14. INFORMANT A. M. Polliet
 (Address) Macon Mo R.F.

15. FILED _____ 19 _____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7' 19 30

17. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at 11 o'clock a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Syph. Infection
45 F
36 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Bacterial Throat
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED U.S.A.
 IF NOT AT PLACE OF DEATH?

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
 WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____
 (Signed) A. M. Polliet, M. D.
 , 19____ (Address) Macon 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 Liberty Cem DATE OF BURIAL 2/9' 19 30

20. UNDERTAKER Stephens & Gooding ADDRESS Macon Mo.

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Macon Registration District No. 933 File No.
 Township Eagle Primary Registration District No. 9714 Registered No. 34
 City (No.) St. Ward

2. FULL NAME

Clara Jamina Pollick
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF A. W. Pollick
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 25 - 1864
 7. AGE YEARS MONTHS Days | If LESS than 1 day, hrs. or min.
65 | 5 | 28
 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)

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 7 1930
 17. I HEREBY CERTIFY, That I attended deceased from 19..... to 19.....
 that I last saw h..... alive on..... 19....., and that death occurred, on the date stated above, at 11 Delora m.
 THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septic Infection
 CONTRIBUTORY Cancer of throat (SECONDARY)
 (duration) yrs. mos. ds.
 (duration) yrs. mos. ds.
 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) A. M. Raines, M. D.
 (Address) Macon Mo

9. BIRTHPLACE (CITY OR TOWN) Macon (STATE OR COUNTRY) Mo
 10. NAME OF FATHER Samuel Elder
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ireland (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Mary Ann Anderson
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind. (STATE OR COUNTRY)

14. INFORMANT A. W. Pollick (Address) Macon Mo 924
 15. FILED 3/31 30 Mrs Luke Dunkle REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Liberty Cem. DATE OF BURIAL 2/9 1930
 20. UNDERTAKER Stephens & Gooding ADDRESS Macon Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement.

6-5658