

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35254

NOV 15 1940

Registration District No. 297

Primary Registration District No. 3016

Registrar's No. 96

1. PLACE OF DEATH:
(a) County Franklin
(b) City or town Washington
(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number on location)
(d) Length of stay: In hospital or institution. 2 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME RALPH Pollock
3. (b) If veteran, name war.
3. (c) Social Security No.

4. Sex Male 5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Howard Samuel Pollock
6. (c) Age of husband or wife if alive. 40 years

7. Birth date of deceased October 16 1940
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
2 hr. 15 min.

9. Birthplace Washington Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business
12. Name Howard Samuel Pollock
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Veronica Irene Coy
15. Birthplace Elahem Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Howard S. Pollock
(b) Address 812 Roberts St., Washington, Mo.

17. (a) Burial (b) Date thereof Oct. 19, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington, Missouri

18. (a) Signature of funeral director Walter H. West
(b) Address Washington, Missouri

19. (a) Oct. 19, 1940 (b) 104 May
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Franklin
(c) City or town Washington
(If outside city or town limits, write "RURAL")
(d) Street No. 812 Roberts
(If rural, give location)
(e) If foreign born, how long in U.S. A. _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 18
year 1940 hour 2:55 minute P. M.
21. I hereby certify that I attended the deceased from Oct 16, 1940
_____ 19____, to Oct 18 1940
that I last saw him alive on Oct 18 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Extracerebral hemorrhage
Macrosclerotic
Due to Heart disease
Due to 1577
Other conditions none to my knowledge
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: no operation
Of operations _____
Of autopsy no autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
2570 (Specify type of place)
While at work? (a) Means of injury _____
23. Signature R. P. Ceeley, M.D. (M. D. or other)
Address Washington, Mo. Date signed Oct 18, 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39
D-1-219511

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.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.