

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

16009

Registration District No. 821 Primary Registration District No. 4553 Registrar's No. _____

1. PLACE OF DEATH:
(a) County Scott
(b) City or town Sikeston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 833 Park Ave
4 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Scott
(c) City or town Sikeston
(If outside city or town limits, write "RURAL")
(d) Street No. 833 Park Ave
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME JOE POLNAMUS.
(b) If veteran, name war —
(c) Social Security No. —

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Apr. day 13
year 1941 hour 9 minute 45 A. M.
21. I hereby certify that I attended the deceased from April 12 1941 to April 13 1941
that I last saw her alive on April 13 1941
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Josella Polnamus 6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased April 12 1861
(Month) (Day) (Year)

Immediate cause of death Paraplegia ✓ Duration 16 hours
Due to Vascular Hypertension and Senility.
Due to _____

8. AGE: Years 80 Months 1 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation Planter

11. Industry or business _____

12. Name William Polnamus

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Anderson

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Joe Polnamus

(b) Address Sikeston Mo

17. (a) Richard (b) Date thereof 4 13 41
(Month) (Day) (Year)

(c) Place: burial or cremation Nichman Ky

18. (a) Signature of funeral director H. S. Barrett

(b) Address Nichman Ky

19. (a) May 6 1941 (b) W. A. Priddy
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of 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? _____

142 (Specify type of place) While at work? (e) Means of injury _____

23. Signature Thomas C. McClure (M. D. or other) _____

Address Sikeston Mo Date signed 4-13-41

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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2

82 H

RECEIVED

District Health Officer No. 2

District File Number 541-562

Date Filed 5/8/41

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 16009

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Scott
(b) City or town Sebastian
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or (days)

3. (a) PRINT FULL NAME Joe Polhamus
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
80 - 1 hr. min.

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

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (b) (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 13
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Stenoplegia Duration _____

Due to Vascular Hypertension and Senility

Due to Cerebral Thrombosis

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature R. C. McClure (M. D. or other)

Address Sebastian, Mo Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
ROWEN & MOORE

SUPPLEMENTAL

