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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

AUG 15 1941

MISSOURI STATE BOARD OF HEALTH
# STANDARD CERTIFICATE OF DEATH

State File No. 24684

Registration District No. 104 | Primary Registration District No. 3008 | Registrar's No. 203

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

**1. PLACE OF DEATH:**
(a) County: Callaway
(b) City or town: Fulton (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital No 1 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 (Specify whether years, months or days)
In this community: 9 mos 7 days

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Mo (b) County: Boone 014 1 2.
(c) City or town: Columbia (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: WILLIAM - POLLOCK
3. (b) If veteran, name war:
3. (c) Social Security No. None
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Mar
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: unknown (Month) 87 (Day) (Year)
8. AGE: Years 87 | Months ? | Days ? | If less than one day ? hr. min.
9. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Farmer
11. Industry or business: Farm
FATHER 12. Name: John Pollock
FATHER 13. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)
MOTHER 14. Maiden name: Sallie Griggs
MOTHER 15. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)
16. (a) Informant: Records
(b) Address:
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Calumpsie Mo
18. (a) Signature of funeral director: W. D. Whitsides
(b) Address: Calumpsie Mo
19. (a) July 29, 1941 (Date received by local registrar) R. N. Crews (Registrar's signature)
106

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 29 year 1941 hour 4 minute A. M.
21. I hereby certify that I attended the deceased from July 1 1941, to July 28 1941, that I last saw him alive on July 28 1941, and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Terminal pneumonia | |
| Due to: chronic myocarditis | |
| Due to: arterio sclerosis | |
| Other conditions (Include pregnancy within 3 months of death) | |

Major findings:
Of operations: 43 P
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: Joseph Lopatrice (M. D. or other) M.D.
Address: State Hospital Fulton Date signed July 29

(Licensed Embalmer's Statement on Reverse Side)

## 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 W. D. Whitaker

Licensed Embalmer No. 3893

P. O. Address Columbia M

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

No. 2B
—8-21-41
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**1. PLACE OF DEATH:**

(a) County: Callaway

(b) City or town: Fulton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Hosp no 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

**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 .....

3. (a) PRINT FULL NAME: William Callaghan

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: M

6. (b) Name of husband or wife: unknown.

6. (c) Age of husband or wife if alive: unk years

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

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

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

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER

12. Name .....

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

14. Maiden name .....

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

16. (a) Informant .....

(b) Address .....

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

(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....

(b) Address .....

19. (a) Sept 13, 1941 (Date received local registrar) (b) R. M. Crewe (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July Day 29 year 1941 hour ..... minute ..... M.

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

| Immediate cause of death | Duration |
|---|---|
| | |
| Due to | |
| Due to | |
| 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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? .....
(Specify type of place)

While at work? ..... (c) Means of injury .....

23. Signature ..... (M. D. or other) .....

Address ..... Date signed .....

SUPPLEMENTARY