

FILED MAR 9 1942
Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 595

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

1. PLACE OF DEATH: Jackson
 (a) County: Kansas City
 (b) City or town: Kansas City
 (c) Name of hospital or institution: K.C. General Hospital No. 10
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 30 days
 In this community 20 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME: Bertha Polly
 3. (b) If veteran, name war: no
 3. (c) Social Security No.: no

4. Sex: Female
 5. Color or race: W
 6. (a) Single, widowed, married, divorced, widow: 2 divorced, widow
 6. (b) Name of husband or wife: Henry Polly
 6. (c) Age of husband or wife if alive: years
 7. Birth date of deceased: Oct-23-1866 (Month) (Day) (Year)

8. AGE: Years 75 Months 3 Days 16 (If less than one day hr. min.)

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

10. Usual occupation: at home

11. Industry or business:

MOTHER FATHER
 12. Name: Samuel Jones
 13. Birthplace: Ind (City, town, or county) (State or foreign country)
 14. Maiden name: Mary Luanda Gilbert
 15. Birthplace: Ind (City, town, or county) (State or foreign country)

16. (a) Informant: Alice Moore
 (b) Address: 614 W-10 St

17. (a) Burial (Burial, cremation, or removal)
 (b) Date thereof: Feb 11 '42 (Month) (Day) (Year)
 (c) Place: burial or cremation: Mt Washington

18. (a) Signature of funeral director: H. C. R. Foster
 (b) Address: 916 Brooklyn

19. (a) 2/10/42 (Date received local registrar)
 (b) M. M. Crome (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State: Missouri (b) County: Jackson
 (c) City or town: Kansas City (If outside city or town limits, write "RURAL")
 (d) Street No.: 614 West 10th St. (If rural, give location)
 (e) If foreign born, how long in U. S. A.? years.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Feb day 9th
 year 1942 hour 6 minutes 15 A.M. M.

21. I hereby certify that I attended the deceased from 1-10-42, 19, to 2-9-42, 19, that I last saw her alive on 2-9-42, 19, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute cerebral hemorrhage- post operative- Operation Repair of Relaxed pelvic floor with Proctodentia
 Due to:
 Due to:
 Other conditions: 139 B³
 (Include pregnancy within 3 months of death)

Major findings: Of operations:
 Of autopsy: See above

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: Henry R. Hoover (M. D. or other)
 Address: Gen. Hospital Date signed

Duration
 PHYSICIAN
 Underline the cause to which death should be charged statistically.

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 _____

Henry C. Brown

Licensed Embalmer No. *2724*

P. O. Address _____

J. C. Mo

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.