

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED FEB 9 1944

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1807 Farson
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 64 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL.")

(d) Street No. 1807 Farson
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Maggie Dollie Pack

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex female 5. Color or race white

6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Thomas W. Pack

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

7. Birth date of deceased Dec. 8 1864
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>79</u>	<u>0</u>	<u>27</u>	hr. _____ min.

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

10. Usual occupation at home

11. Industry or business _____

12. Name Marcellus Polk

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

14. Maiden name Ella Gray Samuel

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

16. (a) Informant Miss Tillie Polk

(b) Address 1807 Farson

17. (a) burial (b) Date thereof 1/8/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Mora

18. (a) Signature of funeral director Heaton Bittole & Bowman

(b) Address 319 So 19

19. (a) 1/6/44 (b) Rose Herzog
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 5 year 1944 hour 1 minute _____ P. M.

21. I hereby certify that I attended the deceased from Jan. 23, 1943 to Jan. 6, 1944 and that death occurred on the date and hour stated above.

that I last saw her alive on Feb. 2, 1943

Immediate cause of death Heart Disease, Arteriosclerosis Duration _____ yrs.

Due to Arteriosclerosis, general

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)

(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 Tillie Polk md (M. D. or O.D.)

Address St. Joseph, Mo. Date signed 1/6/44

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

5-43
17-39
X36671

1083

Dr. N. W. Carle
Phy. + Surg. Bldg.

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 Emel Thomas

Licensed Embalmer No. 2640

P. O. Address. St. Joseph M

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. •

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 67

1. PLACE OF DEATH:
 (a) County Buchanan
 (b) City or town St Joseph
(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 Maggie Nellie Poek
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 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 _____ years

7. Birth date of deceased Dec 8 1886
(Month) (Day) (Year)

8. AGE: Years 79 Months 0 Days _____ If less than one day _____ 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 _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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 Jan day 15
 year 1944 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 Heart Disease
arteriosclerosis
Chor Myocarditis
 Due to arteriosclerosis, general

Due to _____

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?
(Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTAL

IMMEDIATE CAUSE OF DEATH

PHYSICIAN

 Underline the cause to which death should be charged statistically.

938

FEB 15

45-714

12156