

No. 2  
-5-43  
-17-39  
X36671

FILED FEB 28 1944 318

1003

Registration District No. .... Primary Registration District No. ....

1. PLACE OF DEATH:

(a) County .....  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Homer G. Phillips Hospital 0  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 mo. 4 days  
(Specify whether  
In this community 8 years  
years, months or days)

3. (a) PRINT FULL NAME Flora Pollard

3. (b) If veteran, name war ..... 3. (c) Social Security No. ....

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Dec 4<sup>th</sup> 1865  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
78 2 7 hr. min.

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

10. Usual occupation Domestic

11. Industry or business

12. Name Henry Wells

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

14. Maiden name Parlee ? (State or foreign country)

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

16. (a) Informant Cora Jackson

(b) Address 3116 Bell AVE

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-16-44  
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem.

18. (a) Signature of funeral director Ellis Funeral Home

(b) Address 2820 Stoddard St  
FEB 15 1944 (Date received local registrar) (c) J. Z. Bensch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri, (b) County .....  
(c) City or town St. Louis,  
(If outside city or town limits, write "RURAL")  
(d) Street No. 416 So. 23rd  
(If rural, give location)  
(e) Citizen of foreign country? ..... (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 11,  
year 1944 hour 8 minute 55 P. M.  
January

21. I hereby certify that I attended the deceased from 7,  
19 44 to February 11, 19 44;  
that I last saw her alive on February 11, 19 44;  
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic Heart Disease Duration Unk.

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) 93

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 J. E. Smith (M. D. or other) 0  
Address 260 N. Waterloo Date signed 2/15/44

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

844

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 myself

Lonnie Boykin, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

Lonnie Boykin

Licensed Embalmer No.

2946

P. O. Address

St Louis 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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(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 Flora Pollard

3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race C  
6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Chs Pollard  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Dec 4  
(Month) (Day) (Year)

8. AGE: Years 78 Months 2 Days 2  
If less than one day \_\_\_\_\_ min.

9. Birthplace La  
(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) \_\_\_\_\_ (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) MAR 3 1948 (b) J. F. [Signature]  
(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 Feb year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 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)

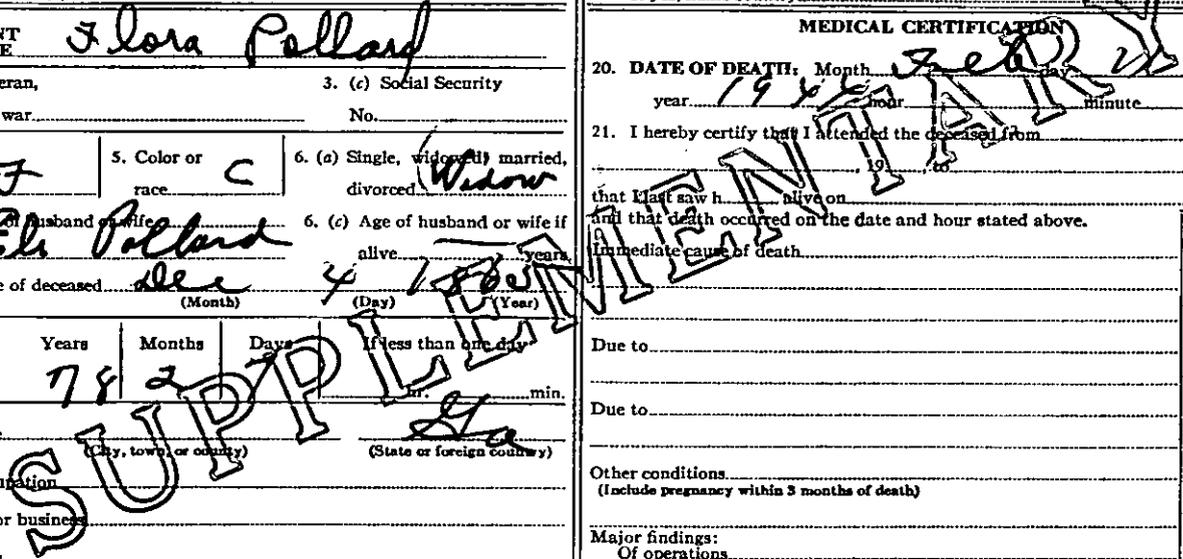
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

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

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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



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