

S. No. 2  
M-9-4-41  
v. 5-17-39  
X29484

8135  
2240

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 16 1945

318

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
4322 Cottage Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
(Specify whether  
In this community..... 35 Years  
years, months or days)

3. (a) PRINT

FULL NAME Mayme E. Polke  
3. (b) If veteran, name war.....  
3. (c) Social Security No. None

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Robert Polke 6. (c) Age of husband or wife if alive 75 years  
7. Birth date of deceased I 14 1874  
(Month) (Day) (Year)

8. AGE: Years 71 Months 2 Days 7 If less than one day hr. min.

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

10. Usual occupation House wife

11. Industry or business

MOTHER FATHER { 12. Name ?  
13. Birthplace Cairo Ill (City, town, or county) (State or foreign country)  
14. Maiden name ?  
15. Birthplace Cairo Ill (City, town, or county) (State or foreign country)

16. (a) Informant Ida May Adams

(b) Address 4522 Aldine

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-10-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director Timothy L. Torrey

(b) Address 3129 Lucas Ave

19. (a) MAR 9 1945 (Date received local registrar) J. F. Budeck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4322 Cottage  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 6 year 45 hour 4:11 minute P.M.

21. I hereby certify that I attended the deceased from 1/15 1945 to 3/5 1945

that I last saw her alive on 3/5 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage of uterus Duration 6 mo

Due to As

Due to As

Other conditions As  
(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) (c) Means of injury

23. Signature E. J. Gregg (M. D. or other) Address 1171 Date signed 3/8/45

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

**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

*Clark Manning*

Licensed Embalmer No. *3371*

P. O. Address *St. Louis*

**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.**