

V. S. No. 2  
100M-5-43  
Rev. 5-17-39  
I X36677

FILED JUN 7 1945  
Registration District No. 2005

Primary Registration District No. 6225

State File No. \_\_\_\_\_  
Registrar's No. 82

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

1. PLACE OF DEATH:

(a) County Bernou

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

(c) Name of hospital or institution: Wash Hospital # 3  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 days  
In this community 1 month 18 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME AUGUST POLZIN

3. (b) If veteran  name war

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive 5 years

7. Birth date of deceased Oct 10 1886  
(Month) (Day) (Year)

8. AGE: Years 88 Months 7 Days 13  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Farming

11. Industry or business farm

MOTHER FATHER

12. Name August Polzin

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

14. Maiden name Witte

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

16. (a) Informant Alfred Polzin

(b) Address Philhowe

17. (a) Removal (b) Date thereof 5-24-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Philhowe

18. (a) Signature of funeral director Marcel Schinger

(b) Address Nevada Mo

19. (a) 5-24-45 (b) Kozel B. Burch  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bernou

(c) City or town Philhowe Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. RFD (If rural, give location)

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

If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 23  
year 1945 hour 10 minute 45 A.M.

21. I hereby certify that I attended the deceased from Apr 1945 to May 23 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Insufficiency ?

Due to Senile Dementia ?

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: ✓

Of operations \_\_\_\_\_

Of autopsy No 953

Duration \_\_\_\_\_

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 R. G. Hall MD  
Address Nevada Mo Date signed 7/3/45

1231

RECEIVED

District Health Officer No. 7,

District file number 540-485-

Date Filed 6-6-43-

**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: Marsh Eickinger

Licensed Embalmer No. 2656

P. O. Address Nevada 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.**