No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 24 1947

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31795

Registration District No. 2506 Primary Registration District No. 5726 Registrar's No. 239

1. PLACE OF DEATH:
(a) County: Macon
(b) City or town: rural Middle Fork
(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 years, months or days)
In this community .....

2. USUAL RESIDENCE OF DEACESED:
(a) State: Mo. (b) County: Macon
(c) City or town: rural
(If outside city or town limits, write "RURAL")
(d) Street No. Eucello Mo. R.F.D.
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: James E. Polson
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M.
5. Color or race: W
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Bertha Polson
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Dec (Month) 22" (Day) 1871 (Year)

8. AGE: Years 75 Months 8 Days 7 If less than one day ..... hr. ..... min.

9. Birthplace: Macon Co. Mo. 0
(City, town, or county) (State or foreign country)
10. Usual occupation: Farming
11. Industry or business: Ben Polson
MOTHER
12. Name: Elizabeth Eubank /
13. Birthplace: Ohio
(City, town, or county) (State or foreign country)
FATHER
14. Maiden name: Elizabeth Eubank /
15. Birthplace: Ohio /
(City, town, or county) (State or foreign country)
16. (a) Informant: Bertha Eubank
(b) Address: Excello Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Woodville Camp
18. (a) Signature of funeral director: Stephens & Gooding
(b) Address: Macon Mo
19. (a) Sept 20 1947 (Date received local registrar) (b) Ruth McNeely (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 29 year 1947 hour 2 minutes 50 A.M.
21. I hereby certify that I attended the deceased from Sept / 1945, to Aug 29 1947 that I last saw him alive on Aug 15 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis — Duration: 2 yrs +
Due to: — 6 mos.
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: GBP
Of autopsy:

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: D. L. Harlan M.D. (M. D. or other) 2
Address: Clarence Mo. Date signed Sept 2 1947.

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

OCT 17 1949

RECEIVED
District Health Officer No.
File Number 9:47:12
Date Filed SEP 23 1947

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 C. L. Stephens

Licensed Embalmer No. 3057

P. O. Address Macon, 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.