

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31489**

FILED SEP 29 1949

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BIRTH NO. _____		REG. DIST. NO. 310		PRIMARY REG. DIST. NO. 3058		Registrar's No. 166	
1. PLACE OF DEATH a. COUNTY St Charles				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lincoln			
b. CITY (If outside corporate limits, write RURAL and give township) St Charles		c. LENGTH OF STAY (in this place) 10 yr		c. CITY (If outside corporate limits, write RURAL and give township) Rural		TOWN Monroe	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph Hosp				d. STREET ADDRESS (If rural, give location) 5 miles East of Troy Mo			
3. NAME OF DECEASED (Type or Print) a. (First) SALOME			b. (Middle) POLLARD			c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) Sept 9 1949		5. SEX F		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	
8. DATE OF BIRTH Aug 23 1885		9. AGE (In years last birthday) 64		10. MONTHS 0		DAYS 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Prof Woodson		13b. MOTHER'S MAIDEN NAME Allie Steel		14. NAME OF HUSBAND OR WIFE Walter Pollard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Walter Pollard			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Carcinoma of ovaries		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ovaries				INTERVAL BETWEEN ONSET AND DEATH 6 mo.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes mell. Ins				7 yrs.	
		DUE TO (c)					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				175X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Generalized abdominal carcinomatous metastases from ovaries					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 9 1949 to Sept 9 1949 that I last saw the deceased alive on Sept 8 1949 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) B. P. Neubeise, M.D.				23b. ADDRESS St. Charles, Mo		23c. DATE SIGNED 9/10/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Sept 12 49		24c. NAME OF CEMETERY OR CREMATORY Calilee Cemetery		24d. LOCATION (City, town, or county) (State) Lincoln County Mo.	
DATE REC'D BY LOCAL REG. 9-21-49		REGISTRAR'S SIGNATURE Faunus Hamilton		25. FUNERAL DIRECTOR'S SIGNATURE Wayne McCoy			
				ADDRESS Troy Mo			

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

District File Number

District Health Officer No. 9,

RECEIVED SEP 27 1949

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

Student Embalmer No.

working under my personal supervision.

Signed *Wayne Mc Coy*

Signed
Student Embalmer

Licensed Embalmer No. *3586*

P. O. Address *Troy 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.