

FILED MAY 15 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12039

|   |   |   |  |  |
|---|---|---|--|--|
| BIRTH NO.   |   | REG. DIST. NO. 42   | PRIMARY REG. DIST. NO. 1000  | Registrar's No. 547  |
| 1. PLACE OF DEATH<br>a. COUNTY Buchanan   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE Kansas b. COUNTY Doniphan   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph   |   | c. LENGTH OF STAY (in this place) 4 yrs.  |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Troy 8150 |
| d. FULL NAME OF HOSPITAL OR INSTITUTION 2621 Mary Street  |   | d. STREET ADDRESS (If rural, give location) 8   |  |  |
| 3. NAME OF DECEASED (Type or Print) Martha C. Pollard<br>a. (First) b. (Middle) c. (Last)   |   |   | 4. DATE OF DEATH (Month) (Day) (Year) May 6 50                                   |  |
| 5. SEX F  | 6. COLOR OR RACE W  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed  | 8. DATE OF BIRTH Aug. 30, 1859   | 9. AGE (In years last birthday) 90   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country) Missouri                               | 12. CITIZEN OF WHAT COUNTRY? U. S. A.  |
| 13a. FATHER'S NAME John C. Morgan   |   | 13b. MOTHER'S MAIDEN NAME Martha Musser   | 14. NAME OF HUSBAND OR WIFE James A. 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 ADDRESS Nora Idlet St. Joseph, Mo.             |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><i>This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>                            |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*<br><i>Septicemic infection</i><br>ANTECEDENT CAUSES<br><i>sublingual and submaxillary abscess cutting mucosa morbid conditions, if any, giving rise to the above cause (do not state the underlying cause last.)</i><br>II. OTHER SIGNIFICANT CONDITIONS<br><i>general atonic</i> |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>5 days</i>                                      |
| 19a. DATE OF OPERATION  | 19b. MAJOR FINDINGS OF OPERATION  |   | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT (Specify) HOMICIDE <i>accident</i>  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>home</i>              | 21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE) <i>St. Joseph Buchanan Mo</i>   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>May 1-1950 10:00</i>   | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? <i>cutting mucosa</i>  |  |  |
| 22. I hereby certify that I attended the deceased from <i>May 2, 1950</i> to <i>May 6, 1950</i> , that I last saw the deceased alive on <i>May 6, 1950</i> , and that death occurred at <i>7:30 p. m.</i> , from the causes and on the date stated above. |   |   |  |  |
| 23a. SIGNATURE <i>Walter Hansen</i> (Degree or title) <i>50</i>   |   | 23b. ADDRESS <i>2802 Julia St.</i>  |  | 23c. DATE SIGNED <i>5/6/50</i>   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>  | 24b. DATE <i>5/6/50</i>   | 24c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>   | 24d. LOCATION (City, town, or county) (State) <i>Troy, Kansas</i>                |  |
| DATE REC'D BY LOCAL REG. <i>May 9, 1950</i>   | REGISTRAR'S SIGNATURE <i>E. B. Jenkins</i> 382  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>E. L. Kau Troy, Kansas</i>  |  |  |

WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed  .....

Signed .....  
Student Embalmer

Licensed Embalmer No. 3532 .....

P. O. Address Troy, Kansas. .....

**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.**