

FILED AUG 2 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24379

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 177

1. PLACE OF DEATH a. COUNTY Randolph		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death) a. STATE Missouri b. COUNTY Randolph	
b. CITY OR TOWN Moberly		c. CITY OR TOWN Moberly	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 312 no Ault	
d. FULL NAME OF HOSPITAL OR INSTITUTION 312 no Ault			

3. NAME OF DECEASED (Type or Print) Kate Pollard			4. DATE OF DEATH (Month) (Day) (Year) July 18th 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Apr. 7th 1871	9. AGE (In years last birthday) 79	10. MONTH 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Basil Hall	13b. MOTHER'S MAIDEN NAME Susan Todd	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>	16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME Mrs Truth Clark	ADDRESS Madison, Mo
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Over work DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 7824
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Natural	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Moberly - Randolph Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Chas. E. Barnes (Degree or title) 3 Coronist	23b. ADDRESS Moberly Mo	23c. DATE SIGNED July 20 1950
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE July 21st 1950	24c. NAME OF CEMETERY OR CREMATORY Fish	24d. LOCATION (City, town, or county) (State) Fish Mo
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DATE REC'D BY LOCAL REG. July 21 - 50	REGISTRAR'S SIGNATURE Leah Bellman Cove	25. FUNERAL DIRECTOR'S SIGNATURE Mahan and Son	ADDRESS Moberly Mo
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

883

SEP 7 1950

RECEIVED JUL 24 1950
District Health Officer No. 10
District File Number 7-50-1200
Date Filed JUL 31 1950

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 _____

working under my personal supervision.

Student Embalmer No.

Signed Frank B. DeWitt

Signed.....
Student Embalmer

Licensed Embalmer No. 3071

P. O. Address Moberly 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.