

FILED MAR 24 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

12168

State File No. \_\_\_\_\_

2547

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2239</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>2627 Indiana Ave.</b>				d. STREET ADDRESS (If rural, give location) <b>23 2627 Indiana Ave.</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph</b> b. (Middle) <b>S.</b> c. (Last) <b>Pollard</b>			4. DATE OF DEATH <b>March 6, 1953</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>August 19, 1895</b>		
9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b>		IF UNDER 1 YEAR Hours _____ Mins. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Independent Packing Co.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Joseph Pollard</b>			13b. MOTHER'S MAIDEN NAME <b>Frances Fearney</b>			14. NAME OF HUSBAND OR WIFE <b>Clara</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____			16. SOCIAL SECURITY NO. <b>489-05-9673</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Clara Pollard</b> ADDRESS <b>2627 Indiana Ave.</b>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Thrombosis</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Chronic Myocardial Disease</b> 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 <b>15 minutes</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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? <b>4222</b>				
22. I hereby certify that I attended the deceased from <b>Jan 4<sup>th</sup>, 1953</b> , to <b>March 6<sup>th</sup>, 1953</b> , that I last saw the deceased alive on <b>March 6<sup>th</sup>, 1953</b> , and that death occurred at <b>8:45 A. M.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>Paul B. Webb M.D.</b>				23b. ADDRESS <b>1915<sup>th</sup> Sidney St.</b>		23c. DATE SIGNED <b>3/6/53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3/9/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Resurrection Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, MO</b>		
DATE REC'D BY LOCAL REG. <b>MAR 7 1953</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John H. Gebken Sons 2630 Gravois Ave.</b>				

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.

Student .....  
Student Embalmer

Signed Robert F. Gebken

Licensed Embalmer No. 4144

P. O. Address 2630 Gravois Ave.

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.