

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **895**

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 112

1. PLACE OF DEATH a. COUNTY GREENE				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY GREENE					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SPRINGFIELD		c. LENGTH OF STAY (In this place) 4 Mo.		c. CITY OR TOWN SPRINGFIELD		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION WERNICK REST HOME 4				e. STREET ADDRESS (If rural, give location) WERNICK REST HOME 03960					
3. NAME OF DECEASED (Type or Print) a. (First) CALVIN			b. (Middle)		c. (Last) POLLACK		4. DATE OF DEATH (Month) (Day) (Year) FEB. 1 1955		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH SEPT. 6 1874		9. AGE (In years last birthday) 80 if UNDER 1 YEAR Months Days if UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY MERCHANT		11. BIRTHPLACE (City and State or Foreign Country) NEAR CAVE SPRINGS, MO. G		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JOSEPH POLLACK			13b. MOTHER'S MAIDEN NAME MARTHA SKEENE			14. NAME OF HUSBAND OR WIFE NELLIE POLLACK (DECEASED)			
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. 500-09-8593		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. JOSEPHINE MACE SPRINGFIELD, MO.				
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.		<p align="center">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinomatous</u> <u>Urinary Tract infection</u> ANTECEDENT CAUSES <u>Cancer of Prostate</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Arteriosclerosis</u> <u>Senility</u></p>						INTERVAL BETWEEN ONSET AND DEATH ?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 177X						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)		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 <u>11/10/55</u> , to <u>2/1/55</u> , that I last saw the deceased alive on <u>1/23/55</u> , 19 <u>55</u> , and that death occurred at <u>7:50a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>David G. Hall, MD</u>				23b. ADDRESS <u>1451 S. National Springfield</u>		23c. DATE SIGNED <u>2/1/55</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE FEB. 3, 55		24c. NAME OF CEMETERY OR CREMATORY CAVE SPRINGS		24d. LOCATION (City, town, or county) (State) CAVE SPRINGS, MO.			
DATE REC'D BY LOCAL REG. 2-2-55		REGISTRAR'S SIGNATURE <u>Walter Williams</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Harmon Schaefer</u>		ADDRESS SPRINGFIELD, MO.		

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.....
Signature of Student Embalmer

Signed *Paul Schumley*.....

Licensed Embalmer No. *147*.....

P. O. Address *Pring*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.

Paul Schumley