

FILED AUG 8 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21217

42

1000

782

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Joseph</u>		c. LENGTH OF STAY (in this place) <u>20440 17 days</u>		c. CITY OR TOWN <u>St Joseph</u>		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 <u>States Hospital no 2</u>				e. STREET ADDRESS (If rural, give location) <u>1816 So 9th St</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sofa</u>			b. (Middle)		c. (Last) <u>Pollak</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 28 - 1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>not given</u>		9. AGE (in years last birthday) <u>abt. 45</u>	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>M. Pollak</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Gremson</u>		14. NAME OF HUSBAND OR WIFE <u>---</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. M.B. Kravitz</u>		ADDRESS <u>4132 78th St K6 Mo</u>	
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) <u>General Carcinomatosis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of breast 2 yrs ago</u>  DUE TO (c) <u>170X</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Dementia Praxica. Hebr. phrenitis p.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>140</u>
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?			
22. I hereby certify that I attended the deceased from <u>Jan 1</u> , 19 <u>53</u> , to <u>July 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>July 27</u> , 19 <u>55</u> , and that death occurred at <u>4:50</u> a.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Forrest Thomas MD</u>				23b. ADDRESS <u>St Joseph Mo 1/2 State Hosp no 2</u>		23c. DATE SIGNED <u>7/28 55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>July 29, 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shaare Sholem Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>		
DATE REC'D BY LOCAL REG. <u>Aug. 4, 1955</u>		REGISTRAR'S SIGNATURE <u>Esther M. Allison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Schaeffer</u>		ADDRESS <u>St. Joseph, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 *Raymond P. Howell*

Licensed Embalmer No. 4413.1

P. O. Address St. Joseph

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.