

THE DIVISION OF HEALTH OF MISSOURI

FILED DEC 2 1955 STANDARD CERTIFICATE OF DEATH

State File No. **38736**
 Registrar's No. **10220**

BIRTH NO. **82820-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		d. STREET ADDRESS (If rural, give location) 2410a North Taylor Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Polk			4. DATE OF DEATH (Month) (Day) (Year) November 2 1955
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH November 2 1955
9. AGE (In years last birthday)		10. UNDER 1 YEAR (Months) (Days)	11. UNDER 18 HRS. (Hours) (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Louis Missouri
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME	
13b. MOTHER'S MAIDEN NAME Margaret Edding Polk		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Margaret Edding Polk		ADDRESS 2410a N. Taylor Ave	
MEDICAL CERTIFICATION			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Length of gestation not compatible to life	
ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		DUE TO (b) _____ DUE TO (c) _____	
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		776X	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 774X	
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 Nov 2 1955 , to Nov 2 1955 , that I last saw the deceased alive on Nov 2 1955 , and that death occurred at 5:40 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE J. B. Ballou M.D.		23b. ADDRESS 630 S. Kingshighway	
23c. DATE SIGNED 11-15-55		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 11-30-55		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE J. Carl Smith	
DATE REC'D BY LOCAL REG. NOV 23 1955		ADDRESS 404 Manchester	

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.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.