

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED FEB 10 1956

No. 300  
10.48

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 547 Registrar's No. 306

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u>		b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Richmond Heights</u>		c. CITY OR TOWN <u>Gardenville</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. LENGTH OF STAY (in this place) <u>4 days</u>		4810			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARYS HOSPITAL</u>			e. STREET ADDRESS (If rural, give location) <u>7804 Fleta Ave.</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>Rose</u>			b. (Middle)		c. (Last) <u>Pollard</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 29 1956</u>	
---	--	--	-------------	--	--------------------------	--	--	--

5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept. 7, 1892</u>		9. AGE (In years last birthday) <u>63</u>		IF UNDER 1 YEAR Months		IF UNDER 1 HOUR Days		IF UNDER 1 MIN. Hours		IF UNDER 1 MIN. Min.	
-----------------	--	---------------------------	--	--	--	--	--	---	--	---------------------------	--	-------------------------	--	--------------------------	--	-------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Evansville, Ind.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
---	--	--	--	--	--	---	--	--	---	--	--

13a. FATHER'S NAME <u>Charles Wasmund</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Clark</u>			14. NAME OF HUSBAND OR WIFE <u>Clarence A. Pollard</u>		
--	--	--	---	--	--	---	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clarence A. Pollard 7804 Fleta Ave.</u>			
---	--	--------------------------------------	--	---	--	--	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Congestive Heart Failure</u>						<u>6 months</u>	
		ANTECEDENT CAUSES							
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) <u>Diabetes Mellitis</u>						<u>14 years</u>	
		DUE TO (c) <u>Nephrosclerosis</u>						<u>3 years</u>	
		II. OTHER SIGNIFICANT CONDITIONS							
		Conditions contributing to the death but not related to the disease or condition causing death.							

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) <u>260x</u>	
--	--	--	--	--	--

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 Aug 19 54, to 28 Jan 1956, that I last saw the deceased alive on 29 Jan 1956, and that death occurred at 12:15P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Arch M. Ahern, M.D.</u>		23b. ADDRESS <u>39 15 Watson Rd</u>		23c. DATE SIGNED <u>29 Jan 56</u>	
--	--	--	--	--------------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Feb. 1, 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>7901 Gravois ave. - St. Louis, Mo.</u>	
---	--	----------------------------------	--	--	--	--	--

DATE REC'D BY LOCAL REG. <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Hornbecker, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hoffmeister Colonial Mortuary 664 Chippewa St., St. Louis, Mo.</u>	
---	--	---	--	---	--

(Licensed Embalmer's Signature on Reverse Side)

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

Dr. A. Kern  
3915 Stalson

**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.....

Licensed Embalmer No. 3871

P. O. Address 7814 S. B.

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.