

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25202

FILED JUL 20 1956

State File No.

318

1003

5958

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS Mo</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>ST. LOUIS</u>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ALEXIAN BROS. Hosp. 16</u>				e. STREET ADDRESS (If rural, give location) <u>3017 WYOMING</u>				
3. NAME OF DECEASED (Type or Print) b. (First) <u>BRUNO</u> c. (Last) <u>POLLOCH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 23 1956</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>NOV. 13 1911</u>		
9. AGE (In years last birthday) <u>44</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 WEEK Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAITER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>SALAS CAFE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
13a. FATHER'S NAME <u>JOHN POLLOCH</u>			13b. MOTHER'S MAIDEN NAME <u>KATHERINE WITOWSKI</u>			14. NAME OF HUSBAND OR WIFE <u>IRENE LORAINÉ POLLACH</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. _____		17. INFORMANT'S SIGNATURE OR NAME <u>IRENE LORAINÉ POLLOCH</u> ADDRESS <u>3017 WYOMING</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>Arterial fibrillation</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Emphysema</u> DUE TO (c) <u>Post operative esophageal diverticulum (causit of diverticulum unknown)</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>21 June '56</u> <u>21 June '56</u> <u>19 June '56</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Esophageal diverticulum with adhesions</u>					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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>539.1</u>				
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>9 June</u> , 19 <u>56</u> , to <u>23 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>23 June</u> , 19 <u>56</u> , and that death occurred at <u>5:30 A.M.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Robert S. Nye, M.D.</u>				23b. ADDRESS <u>3201 Arsenal St. St. Louis Mo</u>		23c. DATE SIGNED <u>23 June 1956</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		24b. DATE <u>JUNE 26 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>S.S. PETER & PAUL</u>		24d. LOCATION (City, town, or county) (State) <u>COLLINSVILLE ILL</u>		
DATE REC'D BY LOCAL REG. <u>JUN 25 1956</u>		REGISTRAR'S SIGNATURE <u>Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kutes</u> ADDRESS <u>2906 Beavis</u>			

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.....
James E. Hill

Licensed Embalmer No. *4347*

P. O. Address *2906 Dav*

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.