

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45197
STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 402

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Elvins</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bonne Terre Hosp.</u>			Length of stay in 1b <u>2 Days</u>	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma Polk</u> First Middle Last				4. DATE OF DEATH <u>Dec 11, 1957</u> Month Day Year				
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 26, 1881</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>	IF UNDER 24 HRS. Hours <u>15</u> 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	11. BIRTHPLACE (City and state or country) <u>Washington Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Doss</u>				14. MOTHER'S MAIDEN NAME <u>Susan Campbell</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>none</u>		17. INFORMANT <u>Alvin Polk, Elvins, Mo.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(massive) cerebral hemorrhage</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
MEDICAL CERTIFICATION	Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>hypertensive cardiovascular disease</u>					about 15 yrs	
		DUE TO (c) <u>generalized (and cerebral) arteriosclerosis</u> <u>4200</u>					unknown	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac decompensation due to hypertensive cardiovascular disease & arteriosclerotic heart disease</u>							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY a. m. _____ p. m. _____			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION			COUNTY		STATE			
21. I attended the deceased from <u>12/10/57</u> to <u>12/11/57</u> and last saw her alive on <u>12-11-1957</u> Death occurred at <u>6:15 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Byron H. Taylor Jr., M.D.</u> (Degree or title)				22b. ADDRESS <u>22 Science, St Flat River, Missouri</u>		22c. DATE SIGNED <u>12-13-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>	<u>Dec-15-1957</u>	<u>St. Francois Memo Pk.</u>		<u>St. Francois Co. Mo.</u>				
24. FUNERAL DIRECTOR <u>Murphy L. Sparks Flat River, Mo.</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>Dec. 13, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Esther. Rudloff</u>			

(Licensed Embolmer's Statement on Reverse Side)

300
1-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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 *Murphy*

Licensed Embalmer No. *423*

P. O. Address *St. Paul, N.H.*

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.