

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017389

STATE FILE NUMBER

FILED JUN 1 1959

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 502 B

S. 300
- 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arizona b. COUNTY Unknown			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN San Carlos		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Medical Center for Federal Prisoners		Length of stay in 1b 19Yr9Mo25Da		d. STREET ADDRESS (If outside, give location) Indian Reservation		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle (none) Last Polk				4. DATE OF DEATH Month 5 Day 20 Year 1959			
5. SEX Male	6. COLOR OR RACE Indian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1911		9. AGE (in years last birthday) 48	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (City and state or country) San Carlos, Arizona		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Amos Polk (Deceased)			13b. MOTHER'S MAIDEN NAME Helen (unknown) Polk		14. NAME OF HUSBAND OR WIFE Zella Zadda (Divorced)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MCFP - Files Springfield, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to airway obstruction						INTERVAL BETWEEN ONSET AND DEATH Minutes	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Epilepsy						Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Mental deficiency, idiopathic						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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.) *****				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			20d. INJURY OCCURRED WHILE AT <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. The Medical Staff attended the deceased from August 1, 1959 to May 20, 1959 and last saw him alive on May 20, 1959 Death occurred at 1:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) J. A. Hunter, M.D. Clinical Director				22b. ADDRESS Medical Center for Federal Prisoners, Springfield, Mo.		22c. DATE SIGNED 5-20-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 22, 1959	23c. NAME OF CEMETERY OR CREMATORY unknown		23d. LOCATION (City, town, or county) (State) San Carlos, Arizona		
24. FUNERAL DIRECTOR Agre-Hoodwin				ADDRESS Springfield Mo. 5-25-59		25. DATE RECD. BY LOCAL REG. 5-25-59	
26. REGISTRAR'S SIGNATURE Effie S. Neelen							

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 *William B. Conter*

Licensed Embalmer No. *4850*
P. O. Address *W. B. Conter*

.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.