

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028194

FILED VS AUG 31 1959 38

Registration District No. 38 Primary Registration District No. 5120 Registrar's No. 392

STATE FILE NUMBER

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| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | Length of stay in 1b <u>Lifetime</u> | c. CITY OR TOWN <u>Columbia</u> | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Boone County Rest Home</u> | | d. STREET ADDRESS (If outside, give location) <u>-----</u> | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>MILDRED</u> Last <u>POLLARD</u> | 4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1959</u> |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-23-1879</u> | 9. AGE (last birthday) <u>79</u> | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u> | 11. BIRTHPLACE (City and state or country) <u>Boone County, Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Daniel J. Cook</u> | 13b. MOTHER'S MAIDEN NAME <u>Micha Turner</u> | 14. NAME OF HUSBAND OR WIFE <u>George T. Pollard</u> |
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| 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>---</u> | 17. INFORMANT Address <u>Mrs. Maude Via, Columbia, Mo.</u> |
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| 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>Arterio Sclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10yr</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Parkinsons Disease</u> | <u>5yr?</u> |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>✓</u> |
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| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> | Month, Day, Year <u> </u> <u> </u> <u> </u> |
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|--|--|---|---------------------|--------------------|
| 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.) <u>Feb 10-59</u> | 20f. CITY, TOWN, OR LOCATION <u> </u> | COUNTY <u> </u> | STATE <u> </u> |
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21. I attended the deceased from Feb-10-59 to Aug-24-59 and last saw her/him alive on Aug 2-59
Death occurred at 3:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>F.C. Suggs M.D.</u> (Degree or title) | 22b. ADDRESS <u>Columbia - Mo</u> | 22c. DATE SIGNED <u>8/26/59</u> (State) |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Aug. 26, 1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u> | 23d. LOCATION (City, town, or county) <u>Columbia, Missouri.</u> |
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| 24. FUNERAL DIRECTOR <u>Carver Funeral Service, Columbia Mo</u> | ADDRESS <u> </u> | 25. DATE RECD. BY LOCAL REG. <u>August 26 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u> |
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

NOV 19 1950

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John Phillips

Licensed Embalmer No. 4897

P. O. Address Columbus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.