

DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 1 1959

59-029267

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3986 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas city mo</i>		Length of stay in 1b <i>70 yrs</i>		c. CITY OR TOWN <i>Kansas city mo</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Research Hospital</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <i>707 W 74th St</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Harry M.</i> Middle <i>Polley</i> Last <i>Polley</i>				4. DATE OF DEATH Month <i>8-</i> Day <i>14-</i> Year <i>1959</i>				
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <i>3-11-1864</i>		
9. AGE (last birthday) <i>95</i>		IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>		IF UNDER 24 HR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired accountant</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Kansas city</i>		11. BIRTHPLACE (City and state or country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13a. FATHER'S NAME <i>James Polley</i>			13b. MOTHER'S MAIDEN NAME <i>Jane Moore</i>			14. NAME OF HUSBAND OR WIFE <i>Edith N Polley</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>493-12-2974</i>		17. INFORMANT <i>Elizabeth Hayes</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <i>Poison Strangulation of Ed Gargraves gall bladder</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <i>Ulcerative Hemorrhagic Enteritis</i>					
			DUE TO (c) <i>Fractured Left Hip (Amoral neck)</i>			<i>2 mths.</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition gives in PART I (a) <i>Chronic Kidney from toxicity on 8-12-59</i>					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			
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.) <i>Terminal Pulmonary Edema</i>				
20c. TIME OF INJURY Hour <i>-</i> a.m. <i>-</i> p.m. <i>-</i>		Month, Day, Year <i>-</i>						
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.) <i>-</i>		20f. CITY, TOWN, OR LOCATION <i>-</i>		COUNTY <i>-</i> STATE <i>-</i>		
21. I attended the deceased from <i>May 24, 1946</i> to <i>Aug 14, 1959</i> and last saw him alive on <i>Aug 13, 1959</i> Death occurred at <i>1:30 A</i> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Earl R. Ferris</i> (Degree or title) <i>MD</i>				22b. ADDRESS <i>535 W 44th St Kansas City 6 mo</i>		22c. DATE SIGNED <i>Aug 14, 1959</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>8-17-59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Elmwood Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas city mo</i>		
24. FUNERAL DIRECTOR <i>France Wornall Funeral Home</i>				25. DATE RECD. BY LOCAL REG. <i>8-17-59</i>		26. REGISTRAR'S SIGNATURE <i>Neva Marshall</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Earl R. Ferris

STATEMENT BY LICENSED EMBALMER

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

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Russell N. Fran

Licensed Embalmer No. 423

P. O. Address K.C. 7

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