

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-020995
STATE FILE NUMBER

AMENDED

FILED JUL 11 1961

Primary Registration District No. 2000

Registrar's No. 594 B

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Green			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY Christian			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield, Mo		Length of stay in lb 3 Months	c. CITY OR TOWN Ozark, Mo R Rt # I		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Burge Protestant Hospital		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) N, Galloway Twsp		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last James R Pollard			4. DATE OF DEATH Month Day Year 6, 15, 1961			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 5/12/1878	9. AGE (last birthday) 83	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	11. BIRTHPLACE (City and state or country) Ray Co, Mo	12. CITIZEN OF WHAT COUNTRY U S A		
13a. FATHER'S NAME George H Pollard		13b. MOTHER'S MAIDEN NAME Margaret Turner		14. NAME OF HUSBAND OR WIFE Ada Pollard		
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.	17. INFORMANT Address Mrs Ada Pollard, Ozark, Mo, Rt # 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>Subarachnoid hemorrhage</i> DUE TO (b) <i>Atherosclerosis</i> DUE TO (c) <i>Senility</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>(Senility)</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 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.)				
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <i>6-15-61 4:20 P M</i> to <i>Death</i> and last saw her alive on <i>6-15-61</i> . Death occurred at <i>6/15/61 4:20 P M</i> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Deceased or title) <i>W. B. Chaffin</i>			22b. ADDRESS <i>Springfield Mo</i>		22c. DATE SIGNED <i>7-7-61</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>6/17/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Selmore</i>	23d. LOCATION (City, town, or county) <i>Christian</i>	(State) <i>MO</i>		
24. FUNERAL DIRECTOR <i>T. B. Chaffin</i>		ADDRESS <i>Ozark, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>7-10-61</i>	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>		

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 T. B. Chaffin

Licensed Embalmer No. 2192

P. O. Address Ozark, Mo.

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.

