

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18609

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>143</u>			
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, write RURAL and give township) OR TOWN <u>Columbia</u>			c. LENGTH OF STAY (In this place) <u>Lifetime</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>			<u>3</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>7 Watson Place</u>				d. STREET ADDRESS (If rural, give location) <u>7 Watson Place</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>DAVID</u> b. (Middle) <u>ELLA</u> c. (Last) <u>POLLARD</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 1, 1949</u>						
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 19, 1863</u>		9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
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		11. BIRTHPLACE (State or foreign country) <u>Boone County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Warren W. Tucker</u>			13b. MOTHER'S MAIDEN NAME <u>Martha Woodruff</u>			14. NAME OF HUSBAND OR WIFE <u>J. Ruby Pollard</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'S SIGNATURE OR NAME ADDRESS <u>R. Searcy Pollard, Columbia, Mo.</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility -</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>4222</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>June, 1948</u> , to <u>June, 1949</u> that I last saw the deceased alive on <u>May 31, 1949</u> , and that death occurred at <u>8:15 p. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Harold D. Dietrich, M.D., Prof. Biol. Sciences</u>				23b. ADDRESS <u>Boone County, Missouri</u>			23c. DATE SIGNED <u>June 3-1949</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>June 3, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Red Top Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Boone County, Missouri</u>				
DATE REC'D BY LOCAL REG. <u>June 7 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>			31		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Parson Funeral Service Columbia Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed JUN 15 1949

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
Student Embalmer

Signed Tom McHarg
Licensed Embalmer No. 4067

P. O. Address Columbus 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 this body is not embalmed, fact should be so stated above.