S. No. 2
I—8-43
5-17-39
I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 19 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3256

Registration District No. 2176 — Primary Registration District No. 4462 — Registrar's No. 240

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

1. PLACE OF DEATH
(a) County St. Francois
(b) City or town Elvins, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community number of yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois 94
(c) City or town Elvins
(If outside city or town limits, write "RURAL")
(d) Street No. — 3
(If rural, give location)
(e) Citizen of foreign country? no 1 (Yes or No)
If yes, name country — 11

3. (a) PRINT FULL NAME John Polette
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M 6
5. Color or race
6. (a) Single, widowed, married, divorced widowed 2
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 12th (Day) 1868 (Year)

8. AGE: Years 76 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Washington Co Mo (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 18 day NOV. year 1944 hour 11 minute P M.
21. I hereby certify that I attended the deceased from NOV 18, 1944, to NOV 18, 1944 that I last saw h/m alive on NOV 18, 1944 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations
Of autopsy

Underline the cause to which death should be charged statistically.

MOTHER
12. Name Chas Polette
13. Birthplace unknown (City, town, or county) (State or foreign country)

FATHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Elmer Cook
(b) Address Elvins, Mo.
17. (a) Burial, cremation, removal (b) Date thereof Nov 22-44
(c) Place: burial or cremation St. Francois Co Mo (Cemetery)
18. (a) Signature of funeral director Caldwell Bros
(b) Address Flat River Mo.
19. (a) Nov 24-44 (Date received local registrar) (b) Forrest Johnson (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature D. Applebury (M. D. or other)
Address Rivermines (P.O.) Mo Date signed 11-22-44

1373

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 4
District File Number 14 S 11
Date Filed 1-16-45

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 ....., ..., Registered Apprentice No. ....., working under my personal supervision.

Signed W.a. Caldwell

Licensed Embalmer No. 3317

P. O. Address Flat River, 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.

No. 2B
5-43
I X36930

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 316 Primary Registration District No. 4462 Registrar's No. 240

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

1. PLACE OF DEATH:
(a) County St Francois
(b) City or town Elvins
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME John Polite
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race (W)
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased May (Month) 12 (Day) 1868 (Year)

8. AGE: Years 76 Months 6 Days Hours Minutes If less than one day

9. Birthplace (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) Ernest Robinson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. Day 18 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from Nov. 16, 1944; that I last saw h alive on Nov. 18, 1944; and that death occurred on the date and hour stated above.

SUPPLEMENTARY

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

3254