

APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

12202

State File No.

Registrar's No.

Registration District No. 796

Primary Registration District No. 6039

54

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Marshall Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2
(Specify whether)

In this community Twenty years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Saline

(c) City or town Marshall Mo. #1
(If outside city or town limits, write "RURAL")

(d) Street No. #1
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME KATIE MARGARET POINTER

3. (b) If veteran, name war: -

3. (c) Social Security No. -

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1941 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from Jan 41 to Mar 13 41
that I last saw her alive on Mar 13 41
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Huston H. Pointer 6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased May 22, 1895
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Chronic Bright's

Other condition Diabetes (Include pregnancy within months of death)

Duration 2 Mos

8. AGE: Years 45 Months 10 Days 22 If less than one day - hr. - min.

9. Birthplace Franklin Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business -

12. Name Joseph Watters

13. Birthplace Franklin Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Hale

15. Birthplace Franklin Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Huston H. Pointer

(b) Address Marshall, Mo.

17. (a) Burial (b) Date thereof 3-15-41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ridge P. cemetery

18. (a) Signature of funeral director J. P. Smith

(b) Address Marshall Mo.

19. (a) 3-15-41 (b) Mary Kent
(Date received local registrar) (Registrar's signature)

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 Mary Kent (M. D. or other) -

Address Marshall Mo. Date signed 3/15/41

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

78

121

JUL 7 1953

RECEIVED
District Health Officer No. 8,
District File Number
Case Filed 4-11-41

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 *J. Leticia Murray*

Licensed Embalmer No. *2235*

P. O. Address *Wendell*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12202

Registration District No. 796

Primary Registration District No. 6039

Registrar's No. _____

1. PLACE OF BIRTH:
(a) County Saline
(b) City or town Marshall Twp
(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 _____)
In this community _____
years, months or days)

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 Katie Margaret Painter
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex F 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 _____ year _____
7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

20. DATE OF DEATH: Month Mar day 13
year 1941 hour _____ minute _____ PM.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above _____
(Specify cause of death) Cerebral Hemorrhage Duration _____

8. AGE: Years 45 Months 10 Days 22 If less than one day _____ hr _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

Due to Hypertension 1941
Due to Chronic Bright's disease
Other conditions Pregnant 5 months
(Include pregnancy within 3 months of death)
Mo delivered
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

MOTHER FATHER {
16. (a) Informant _____ (b) Address _____
17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____
18. (a) Signature of funeral director _____ (b) Address _____
19. (a) _____ (b) _____
(Date received local registrar) (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?
While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed 1/13/41

SUPPLEMENTARY

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

5-12202

SEARCHED INDEXED

APR 31 1951