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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JUL 16 1945

State File No. 23332

Registration District No. 1 Primary Registration District No. 4001 Registrar's No. 142

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Novinger (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 Mo (b) County Adair

(c) City or town Novinger Mo (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? yes no (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Patty Joe Pointer

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced —

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 6 (Month) 2 (Day) 1945 (Year)

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Novinger (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name Henry H. Pointer
13. Birthplace (City, town, or county) Mo. 0 (State or foreign country)

MOTHER
14. Maiden name Matilla Owings
15. Birthplace (City, town, or county) Colo. 1 (State or foreign country)

16. (a) Informant Matilla Pointer
(b) Address Novinger Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-6-45 (Month) (Day) (Year)
(c) Place: burial or cremation Novinger Cem.

18. (a) Signature of funeral director Glenn E. Kent & Son
(b) Address Green City Mo

19. (a) 6-8-45 (Date received local registrar) (b) Mrs. J. L. Wagner (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 5 year 1945 hour 2 minute 8 M.

21. I hereby certify that I attended the deceased from June 2, 1945 to June 5, 1945; that I last saw her alive on June 5, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Premature Birth

Due to Seven month Baby

Due to ✓

Other conditions (Include pregnancy within 3 months of death) ✓

Major findings: Of operations ✓

Of autopsy ✓

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 H. T. Garrison M.D. (M. D. or other)

Address Novinger Mo. Date signed 6-5-45

1049

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 7-45-1145
Date Filed JUL 13 1945

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~~ Not Embalmed, Registered Apprentice No. —, working under my personal supervision.

Signed Archie W Wade

Licensed Embalmer No. 3037

P. O. Address Greenville

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.