

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3996

State File No.

FILED MAR 1 1949

BIRTH NO. _____		REG. DIST. NO. <u>27</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>78</u>			
1. PLACE OF DEATH a. COUNTY <u>Bates</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY <u>Bates</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Butler Mo</u>		c. LENGTH OF STAY (in this place) <u>U</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>P.O. Merwin Mo. West boone</u>		d. STREET ADDRESS (If rural, give location) <u>3 miles S.E. Drexel, Mo</u>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Butler Memorial Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3 miles S.E. Drexel, Mo</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>CLARA</u> b. (Middle) <u>JONES</u> c. (Last) <u>POINDEXTER</u>			4. DATE OF DEATH <u>Feb - 20 - 1949</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Feb. 21 - 1880</u>		9. AGE (In years last birthday) <u>69</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u>		IF UNDER 2 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Henry Co. near Johnston, MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>John Murphy Jones</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Jane Cliffo</u>		14. NAME OF HUSBAND OR WIFE <u>Larkin Money Poindexter</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lee Flanary Archie, Mo</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u></u>		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo approx</u>	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>Carcinoma of Stomach</u>							
		ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>							
		DUE TO (b) <u>151X</u>							
		DUE TO (c) <u>none</u>							
		II. OTHER SIGNIFICANT CONDITIONS <u>none</u>							
19a. DATE OF OPERATION <u>2-17-49</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma - pyloric end of stomach - end half of fundus</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21c. (CITY, TOWN, OR TOWNSHIP), (COUNTY), (STATE) <u></u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u></u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>					
22. I hereby certify that I attended the deceased from <u>Feb. 12, 1949</u> , to <u>Feb. 17, 1949</u> , that I last saw the deceased alive on <u>Feb. 17, 1949</u> , and that death occurred at <u>8:45 a.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>E. E. Robinson</u>				23b. ADDRESS <u>M.O. Adrian, Mo.</u>		23c. DATE SIGNED <u>2-28-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Feb. 27, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sharon Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>3 M. East Drexel Mo</u>			
DATE REC'D BY LOCAL REG. <u>Mar-1-49</u>		REGISTRAR'S SIGNATURE <u>Rendall Kersey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Atkinson Brothers</u>		ADDRESS <u>Archie, Mo.</u>			

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

RECEIVED

District Health Officer No. 7

District File Number 2-49-181

Date Filed 3-12-09

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed ~~by~~ or by

Bill Gullik Student Embalmer No. 154

working under my personal supervision.

Signed Bill D. Dickey Student Embalmer

Signed Hayd C. Johnson

Licensed Embalmer No. 3920

P. O. Address Johnson

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.