

RID DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-015978

FILED VS MAY 12 1960

Registration District No. 174 Primary Registration District No. 3e35 Registrar's No. 48

STATE FILE NUMBER

DED

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Barfayette | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Missouri Barfayette | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Lexington | | Length of stay in 1b 48 Years | | c. CITY OR TOWN Lexington | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 304 S. 27th. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 304 S. 27th. St. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First DAVID Middle CHRISTOPHER Last POINTER | | | | 4. DATE OF DEATH Month May Day 6 Year 1960 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. BIRTHDATE February 5, 1910 | 9. AGE (last birthday) 50 | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Natural Gas Service | | 10b. KIND OF BUSINESS OR INDUSTRY Public Utility | | 11. BIRTHPLACE (City and state or country) Mayview, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S.A | |
| 13a. FATHER'S NAME David C. Pointer | | | 13b. MOTHER'S MAIDEN NAME Mary Gray | | 14. NAME OF HUSBAND OR WIFE Izola Dillon Pointer | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give dates of service) yes November 1942 August 4, 1943 | | | 16. SOCIAL SECURITY NO. 486-09-4690 | | 17. INFORMANT Mrs. Izola Pointer Lexington Mo | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO (b) Coronary atherosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH none years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. | | Month, Day, Year | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from Nov 11 1956 to May 6, '60 and last saw him alive on March 5 1960 Death occurred at 2:00 A. M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>Alphon W. Kelly</i> (Degree or title) M.D. | | | | 22b. ADDRESS Lexington, Mo. | | 22c. DATE SIGNED 5-6-60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 5/8/60 | 23c. NAME OF CEMETERY OR CREMATORY Nachpelah Cemetery | | 23d. LOCATION (City, town, or county) Lexington, Mo. | | (State) |
| 24. FUNERAL DIRECTOR Crunk-Walker Lexington, Mo | | | | 25. DATE RECD. BY LOCAL REG. 5-7-60 | | 26. REGISTRAR'S SIGNATURE <i>Thomas G. ...</i> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 7 1960

STATEMENT BY LICENSED EMBALMER

MAY 13 1960

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Harold L. Walker

Licensed Embalmer No. 4588

P. O. Address Lexington

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.