

MAY 10 1943

State File No.

Registration District No. 57Primary Registration District No. 5208Registrar's No. 7

1. PLACE OF DEATH:

(a) County Carroll
 (b) City or town Purs Hall-Hurricane
 (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.....
 In this community 13 yrs. (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Ison Luther Poindexter

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 5. Color or face White 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Wife Nancy M. Poindexter 6. (c) Age of husband or wife if alive 51 years
 7. Birth date of deceased Aug 18 1879
 (Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 3 If less than one day hr. min.9. Birthplace Winn Creek, Mo. (City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business

MOTHER FATHER
 12. Name Hiring Poindexter
 13. Birthplace North Carolina (City, town, or county) (State or foreign country)
 14. Maiden name Mary Saltzman
 15. Birthplace Linn County Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. Poindexter (b) Address Hale Mo17. (a) Burial (b) Date thereof Apr. 23-43 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Johnston18. (a) Signature of funeral director Frank E. Slater(b) Address Hale Mo19. (a) April 23-43 (b) Mrs. Edger Smith (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Carroll
 (c) City or town Purs Hall-Hurricane
 (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..... A

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21 year 1943 hour 10 minute A M.

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.

Immediate cause of death.....
Chronic heart disease ✓ 5 yrs.

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?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Dr. Alvin A. Ullrich (M. D. or other) P.O.
Address Hale, Mo Date signed 4-21-43

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed ~~4-22-43~~

5-7-43

DEC 29 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, Registered Apprentice No.
working under my personal supervision.

Signed *Frank E. Slater*

Licensed Embalmer No. *937*

P. O. Address. *716 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13962

Registration District No. 3-7

Primary Registration District No. 5208

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Carroll

(b) City or town Rural
(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 _____ 13 yrs (Specify whether _____ years, months or days)

3. (a) PRINT FULL NAME Leon L Pain det er

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 m

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Aug 18 - 1874
(Month) (Day) (Year)

8. AGE: Years 63 Months 6 Days 24 If less than one day _____ 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)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carroll

(c) City or town Rural
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day _____ year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Chronic heart disease
Due to Chronic endocarditis

mitral stenosis
Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

PHYSICIAN g d d

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Dr. A. A. Ulsh (M. D. or other) DO

Address Hale, Mo Date signed _____

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



