

FILED NOV 2 1944
Registration District No. **877**

Primary Registration District No. **4143-**

Registrar's No. **116**

1. PLACE OF DEATH:

(a) County **Cooper**
(b) City or town **Blackwater**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Home 1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **30 years** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Cooper**
(c) City or town **Blackwater Mo.**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **George Poindexter**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **495-09-014**

4. Sex **male** 5. Color or race **Brown** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Hella Poindexter** 6. (c) Age of husband or wife if alive **50 years**
7. Birth date of deceased: (Month) **12** (Day) **24** (Year) **1879**

8. AGE: Years **64** Months **9** Days **17** If less than one day hr. _____ min. _____

9. Birthplace **Saline County** (City, town, or county) (State or foreign country)

10. Usual occupation **Labourer**

11. Industry or business **II**

MOTHER FATHER { 12. Name **Mose Poindexter**
13. Birthplace **Virginia** (City, town, or county) (State or foreign country)
14. Maiden name **Mary Lewis**
15. Birthplace **Missouri** (City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Stella Poindexter**

(b) Address **Blackwater Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10 15 44** (Month) (Day) (Year)

(c) Place: burial or cremation **Nelson Missouri**

18. (a) Signature of funeral director **J. Burr Alford**

(b) Address **405 W. Cooper**

19. (a) **Oct-12-44** (Date received local registrar) (b) **Dr. Chas. Swap** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **11** year **1944** hour **5** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **Oct 4**, 19**44**, to **Oct 11**, 19**44**, that I last saw him alive on **Oct 11**, 19**44**, and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Myocarditis**
Solar pneumonia

Due to _____

Due to **108**

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 **J. W. Hunt** (M.D. or other) **D.O.**

Address **Blackwater Mo.** Date signed **10-11-44**

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

7
0
0

1088

RECEIVED

Health Officer No. 3.

Number

11-1-44

DEC 1 1944

DEC 1 1944

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. 4245

working under my personal supervision.

Signed

J. L. Albright

Licensed Embalmer No. 4246

P. O. Address

Sedalia 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.