

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

FILED JAN 28 1946

3766

Do not use this space.

1. PLACE OF DEATH

(a) County Putnam Registration District No. 291
 (b) Township York Primary Registration District No. 5998 Registered No. 19
 (c) City Powersville, Mo. (d) Street No. 1 St. 0
(If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds. 0

2. PRINT FULL NAME Daisy Points,

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed ✓
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Art Points,

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
70 5 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at none
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

FATHER 13. NAME John Hayworth

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) IOWA

MOTHER 15. MAIDEN NAME Matilda Eli

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Iowa

17. INFORMANT Mr. Don Points, (ADDRESS) Powersville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Edmond Cem. Iowa DATE Dec. 1, 1945

19. FUNERAL DIRECTOR (NAME) Beary-Benton Co., (ADDRESS) Powersville, Mo.

20. FILED 19 Marvell Dushin Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19 45

22. I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1945, to Nov. 26, 1945

I last saw her alive on Nov. 26, 1945. Death is said to have occurred on the date stated above, at 2:45 p.m.

The principal cause of death and related causes of importance were as follows:

Cardiac failure
due to
Lobar pneumonia

Date of onset

Other contributory causes of importance:

108

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____ (Signed) G. C. Dale D.O.

(Address) Newtown, Mo.

12-15-45-261

100777

RECEIVED

District Health Officer No.

District File Number 1-46-12

Date Filed JAN 24 19

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 me

....., Registered Apprentice No.

working under my personal supervision.

Signed Paul Nass

Licensed Embalmer No. 2634

P. O. Address Bunilton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 291

Primary Registration District No. 5998

Registrar's No. 79

1. PLACE OF DEATH:

(a) County Putnam
 (b) City or town York Springs
(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)

3. (a) PRINT FULL NAME Raisy Poivits

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

4. Sex F 5. Color or race w 6. (a) Single, widowed, married, divorced wid

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

7. Birth date of deceased.....
(Month) (Day) (Year)

8. AGE: Years Months Days 70 If less than one day hr. 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..... (b) County.....
 (c) City or town.....
(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 Feb Day 26 Year 1945 Hour 10:01 minute..... M.

21. I hereby certify that I attended the deceased from.....
 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.....

Duration

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 Ed Dale (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

MOTHER FATHER

3706