

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED FEB 10 1947

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43719

State File No.

Registration District No. 373

Primary Registration District No. 6269

Registrar's No.

1. PLACE OF DEATH:

(a) County Webster Co  
(b) City or town Rural Ozark  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
R. T. D. Marshfield Mo 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Webster 112  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Marshfield Mo  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country X

3. (a) PRINT FULL NAME ROSA BELL POINDEXTER

MEDICAL CERTIFICATION

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

20. DATE OF DEATH: Month Dec day 31  
year 1946 hour 10: minute A.M.

4. Sex F 5. Color or race W 6. (a) ~~Single~~ widowed, married, divorced  
6. (b) Name of husband or wife U.S. 6. (c) Age of husband or wife if alive 73 years  
7. Birth date of deceased: Oct 29 1876  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Dec. 15 1946 to Dec. 31 1946; that I last saw her alive on Dec. 31 1946; and that death occurred on the date and hour stated above.

8. AGE: Years 70 Months 2 Days 2 If less than one day  
hr. min.

Immediate cause of death: Hemiplegia, left, total Duration 6 days  
Due to Cerebral Thrombosis 6 days  
Due to Cardiac Disease - Myocarditis, Chronic over 4 years  
Other conditions: Chron. Cholecystitis over 4 yrs.  
(Include pregnancy within 3 months of death)

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business

12. Name John Stovall  
13. Birthplace Kien (City, town, or county) (State or foreign country)  
14. Maiden name Nancy Johnson  
15. Birthplace Kien (City, town, or county) (State or foreign country)

Major findings: PP  
Of operations:  
Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

16. (a) Informant Max Fred Cantrell  
(b) Address Marshfield Mo

17. (a) (Burial, ~~cremation~~) (b) Date thereof 1-3-47  
(Month) (Day) (Year)

(c) Place: burial or cremation Marshfield Mo

18. (a) Signature of funeral director Ray Kainy

(b) Address Marshfield Mo

19. (a) 1/28/47 (b) J. M. McKinney  
(Date received local registrar) (Registrar's signature)

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 C. P. Macdonald (M. D. or other) M.D.  
Address Marshfield, Mo. Date signed 1/28/47

544

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 6,

District File Number 247-190

Date Filed FEB 6 1947

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..... *Lex R. Harris* .....

Licensed Embalmer No. 3312

P. O. Address Marshfield 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.