No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37822

FILED NOV 25 1947

Registration District No. 1528

Primary Registration District No. 5465

Registrar's No. 981

1. PLACE OF DEATH:

(a) County Greene

(b) City or town Rural - Springfield N. Campbell Twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Greene County Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community 63 Yr. 3 Mo. 27 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39

(c) City or town Springfield - Rural 0
(If outside city or town limits, write "RURAL") 0

(d) Street No. R. F. D. # 4
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Joseph Newton Poinor

3. (b) If veteran, name war None

3. (c) Social Security No. 499-07-1182

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife .....

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

7. Birth date of deceased April 16, 1884
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
63	6	27	..... hr. ..... min.

9. Birthplace Strafford Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Contractor

11. Industry or business Construction

FATHER
12. Name George Poinor
13. Birthplace ..... Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Creson
15. Birthplace ..... Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Belle Caffey,
(b) Address Springfield Mo.

17. (a) Burial (b) Date thereof 11-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Danforth Cem.

18. (a) Signature of funeral director J W Klingner & Co.
(b) Address Springfield Mo.

19. (a) 11-15-47 (b) W E Hardley M D
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 13, year 1947 hour 2 minute 55 P. M.

21. I hereby certify that I attended the deceased from May 8, 1947, to Nov. 13, 1947 that I last saw him alive on Nov 12, 1947 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Arteriosclerosis

Due to .....

Due to .....

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

Major findings:
Of operations .....
Of autopsy .....

Duration: several months unk.

PHYSICIAN
Underline the cause of 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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature James R Amos (M. D. or other) M.D.

Address Springfield Mo Date signed 11-15-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

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 Max Rhodes

Licensed Embalmer No. 4071

P. O. Address Springfield

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.