

FILED JUN 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19333

State File No.

BIRTH NO. _____ REG. DIST. NO. 137 PRIMARY REG. DIST. NO. 3023 Registrar's No. 154

1. PLACE OF DEATH a. COUNTY <u>HENRY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Henry</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clinton</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clinton Mo</u>	
c. LENGTH OF STAY (in this place) <u>20 years</u>		d. STREET ADDRESS (If rural, give location) <u>220 W Green St</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>HOME</u>			

3. NAME OF DECEASED (Type or Print) <u>FLOYD</u>	a. (First)	b. (Middle)	c. (Last) <u>POINTER</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>6-11-49</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MAR</u>	8. DATE OF BIRTH <u>MARCH 1, 1898</u>	9. AGE (In years last birthday) <u>51</u> Months <u>3</u> Days <u>10</u>	IF UNDER 1 YEAR Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>union Chemist</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>BELL Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Stephen Pointer</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Howard</u>	14. NAME OF HUSBAND OR WIFE <u>Grace Pointer</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>491-20-0891</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Grace Pointer</u> ADDRESS <u>Clinton Mo</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>75 min</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Thrombosis</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			<u>(4201)</u>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 29 Feb., 1948, to June 11, 1949, that I last saw the deceased alive on June 11, 1949, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James Smith M.D.</u>	23b. ADDRESS <u>Clinton, Mo.</u>	23c. DATE SIGNED <u>June 13, 1949</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/15/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Englewood Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Clinton Mo</u>
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DATE REC'D BY LOCAL REG. <u>June-15-49</u>	REGISTRAR'S SIGNATURE <u>Florence Adair</u>	425	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Consoled</u> ADDRESS <u>Clinton Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 20 1950

RECEIVED
District Health Officer No.
District File Number 5-49-
Date Filed 11-20-50

DEC 7 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____
Student Embalmer

Signed

J. E. Condon
Licensed Embalmer No. 1891

P. O. Address _____

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.