

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31763

State File No. 7989

No. 300  
10-48

FILED SEP 22 1951

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marias	
b. CITY (If outside corporate limits, write RURAL and give town/ST. Louis, Missouri)		c. CITY (If outside corporate limits, write RURAL and give township) Belle 0630	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital			
3. NAME OF DECEASED a. (First) Gail b. (Middle) C c. (Last) Pointer			4. DATE OF DEATH (Month) (Day) (Year) Sept 7, 1951
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH Nov 11, 1907
9. AGE (In years last birthday) 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Oklahoma /
10b. KIND OF BUSINESS OR INDUSTRY Farming		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME James Pointer		13b. MOTHER'S MAIDEN NAME Stella Eaton	14. NAME OF HUSBAND OR WIFE Nil
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Michael Michlo-Wilmington, Delaware
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Sarcoidosis. DUE TO (c) Hypertension. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 138.0			
22. I hereby certify that I attended the deceased from 2-0-51, 19, to 9-7-51, 19, that I last saw the deceased alive on 9-7-51, 19, and that death occurred at 15P m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) John H. Kennedy M.D. C.M.		23b. ADDRESS D. 508 no Ascend.	
23c. DATE SIGNED 9-8-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-7-51	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Belle, Missouri	
DATE REC'D BY LOCAL REG. SEP 8 1951		REGISTRAR'S SIGNATURE J. Earl Smith M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Albert H. Hoppe-4700 Washington Blvd			

(Licensed Embalmer's Statement on Reverse Side)

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

SEP 26 1981

**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.

Student .....  
Student Embalmer

Signed John J. Haines

Licensed Embalmer No. 4108

P. O. Address St. Louis 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.