RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-60-037969

STATE FILE NUMBER

FILED VS OCT 25 1960

Registration District No. 119 Primary Registration District No. 4191 Registrar's No. 28

DED

1. PLACE OF DEATH
a. COUNTY GASCONADE
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GASCONADE — Length of stay in 1b 13 YRS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ✓ ✓ — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY GASCONADE
c. CITY OR TOWN GASCONADE — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First MARQUIS Middle D. L. Last POINTER

4. DATE OF DEATH Month OCT. Day 17 Year 1960

5. SEX MALE

6. COLOR OR RACE CAV.

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 10/18/1873

9. AGE (last birthday) 86 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY FARMING

11. BIRTHPLACE (City and state or country) COOPER HILL, Mo

12. CITIZEN OF WHAT COUNTRY U.S.

13a. FATHER'S NAME John POINTER

13b. MOTHER'S MAIDEN NAME LOUISA McGOWAN

14. NAME OF HUSBAND OR WIFE DORA POINTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. NONE

17. INFORMANT MRS JESSE OWENS, Address GASCONADE, Mo

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute medullary failure	5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cerebral anoxia	
DUE TO (c)	Cerebral appoplexy	16 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 2/8/51, to 10/17/60 and last saw ☒ him alive on 10/17/60
Death occurred at 12:21 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) W. A. Foster, Wall.

22b. ADDRESS Hermann, Mo.

22c. DATE SIGNED 10/18/60

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE 10/19/60

23c. NAME OF CEMETERY OR CREMATORY GASCONADE CEMETERY

23d. LOCATION (City, town, or county) GASCONADE (State) Mo.

24. FUNERAL DIRECTOR HUGO H. BLUMER ADDRESS HERMANN Mo

25. DATE RECD. BY LOCAL REG. 10-18-60

26. REGISTRAR'S SIGNATURE Delma Uffelman

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed b

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____

Signature of Student Embalmer

Licensed Embalmer No. 3160

P. O. Address Hermann

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.