

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-031988

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 922

AMENDED

FILED SEP 18 1961

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Length of stay in 1b 11 years		c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2307 35th Terrace			d. STREET ADDRESS (If outside, give location) 2307 35th Terrace		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First JENNIE Middle F. Last POYNTER			4. DATE OF DEATH Month September Day 10 Year 1961		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1879	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (City and state or country) Bigelow, Missouri	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Horace McKee		13b. MOTHER'S MAIDEN NAME Sarah Scott	
14. NAME OF HUSBAND OR WIFE George W. Poynter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. INFORMANT Mrs. Thomas Hunter		Address 2507 35th Terrace St. Joseph, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration & suffocation Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pharyngeal & laryngeal paralysis DUE TO (c) Bulbar, myasthenia gravis					INTERVAL BETWEEN ONSET AND DEATH 3 days 7 years 7 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) Thymoma; Cerebral & General Arteriosclerosis					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
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 10/30/56 to 9/10/61 and last saw her alive on 9/10/61 Death occurred at 3:45 a. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Beryl A. Toller, M.D.			22b. ADDRESS Phys & Surg. Bldg. St. Joseph, Mo		22c. DATE SIGNED 9/12/61
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 9/12/1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery	
23d. LOCATION (City, town, or county) Mound City Missouri		24. FUNERAL DIRECTOR Heston-Bowman, St. Joseph, Mo.			
25. DATE RECD. BY LOCAL REG. Sept. 14, 1961		26. REGISTRAR'S SIGNATURE Mrs. Clark Handell			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION
C.A. Patten, M.D.

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 _____
Signature of Student Embalmer

Signed William Spading

Licensed Embalmer No. 4535

P. O. Address St Joseph 210

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.