

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-047359

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3377 STATE FILE NUMBER

FILED DEC 18 1961

1. PLACE OF DEATH
 a. COUNTY **ST. LOUIS**
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **JEFFERSON BARRACKS, MO.** Length of stay in 1b **34 DAYS**
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **VETERANS ADM. HOSPITAL** Inside Limits Yes No
 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **MISSOURI** b. COUNTY **GASCONADE**
 c. CITY OR TOWN **BLAND** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **RFD # 3** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last 4. DATE OF DEATH Month Day Year
CHARLES CLETIS POINTER **11 28 1961**
 5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. Married Never Married Widowed Divorced
 8. DATE OF BIRTH **2-17-88** 9. AGE (last birthday) **72 YRS** 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) **OSAGE COUNTY, MO.** 12. CITIZEN OF WHAT COUNTRY **USA**
 13a. FATHER'S NAME **FRANTZ POINTER** 13b. MOTHER'S MAIDEN NAME **OWENS** 14. NAME OF HUSBAND OR WIFE **NONE**
 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **YES WW-I** 17. INFORMANT Address **LESLIE POINTER RFD 3, BLAND, 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) **VENTRICULAR FIBRILLATION** INTERVAL BETWEEN ONSET AND DEATH **3 HOURS**
 DUE TO (b) **AURICULAR FINRILLATION** **5 YEARS**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) **ARTERIOSCLEROTIC HEART DISEASE** **20 YEARS**
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **INTESTINAL OBSTRUCTION, SIGMOIDITIS, POLYPS & DIVERTICULAE** 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 Month, Day, Year. a.m. p.m.
 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 **10-25-61** to **11-28-61** Death occurred at **4:45** A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Sam Nichols **JEFF BRKS, 25, MO.** **11-28-61**

23a. BURIAL, CREMATION, or other disposal (Specify) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town, or county) (State)
Removal **12/1/61** **College Hill** **Osage County Mo.**
 24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE
Edward Belle **11-29-61** **John C. Murphy Md**

DOCUMENT BY AFFIDAVIT OF MEDICAL CERTIFICATION

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 *Omer Edward Jones*

Licensed Embalmer No. 4411

P.O. Address Belle me

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.