

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

Do not use this space.

5401

1927

1. PLACE OF DEATH

County Marion Co. Registration District No. 547  
Township Marion Primary Registration District No. 3019  
City Hannibal (No. Leaning Hospital St. 6 Ward)

File No. \_\_\_\_\_  
Registered No. 546

2. FULL NAME

(a) Residence. No. 309 S. 5<sup>th</sup> St. 3 Ward.  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male  
4. COLOR OR RACE White  
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-13-1927

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Mrs. Ona Potosch

17. I HEREBY CERTIFY, That I attended deceased from 1-15-1927, to 2-13-1927, that I last saw him alive on 2-13-1927, and that death occurred, on the date stated above, at 1, 9 m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
58 | 11 | 19

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Influenza  
Septicemia (duration) yrs. 1 mos. 1 da.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Railway Conductor  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

CONTRIBUTORY (SECONDARY) Septicemia (duration) yrs. 9 mos. 9 da.

9. BIRTHPLACE (CITY OR TOWN) Brownstown  
(STATE OR COUNTRY) Ill.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER Henry Potosch

DID AN OPERATION PRECEDE DEATH? No DATE OF.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) German  
(STATE OR COUNTRY)

WAS THERE AN AUTOPSY? No

12. MAIDEN NAME OF MOTHER Ona Keller

WHAT TEST CONFIRMED DIAGNOSIS? Clinical course  
(Signed) Howard B. Goodrich, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ohio  
(STATE OR COUNTRY)

2-17-1927 (Address) Hannibal, Mo.

14. INFORMANT Mr. John Potosch  
(Address) Hannibal, Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

15. FILED 2/17/27 O. C. Stode  
REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL West Hill Cemetery DATE OF BURIAL 2-15-1927

20. UNDERTAKER James Donnell ADDRESS Hannibal

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Every item of information should be carefully supplied.



**MISSOURI STATE BOARD OF HEALTH**  
**BUREAU OF VITAL STATISTICS**  
**CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
 FOR MUST BE WRITTEN ON  
 THIS SUPPLEMENTARY.

#395  
 542

1. PLACE OF DEATH  
 County Marion Registration District No. 547 File No. ....  
 Township Samuel Primary Registration District No. 3029 Registered No. 34  
 City Samuel (No. ....) St. .... Ward) .....

2. FULL NAME Jacob Watsch  
 (a) Residence No. .... St. .... Ward. .... (If nonresident give city or town and State)  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M.

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 13 1927

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

17. I HEREBY CERTIFY That I attended deceased from ..... to ..... 19..... that I last saw h. .... alive on ..... 19..... and that death occurred, on the date stated above at..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 25-1868

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
58 11 19 0 0 0

Septicemia  
with the arthritis  
acute pneumonic fever

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

CONTRIBUTORY (SECONDARY) Septicemia  
 (duration) yrs. mos. ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) ..... M. D.

, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE CAUSED, state (1) MANNER AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 9/17 27 W. Shote REGISTRAR

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW.

SUPPLEMENTARY

1543-S