

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

Do not use this space.

1072

1. PLACE OF DEATH
 County GREENE Registration District No. 317
 Township REPUBLIC Primary Registration District No. 5436
 City..... (No.....) St. Ward.....
 File No.....
 Registered No.....

2. FULL NAME EMILIA ANN POTTS
 (a) Residence No. REPUBLIC NO St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE of _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) JUNE 6th 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 20

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 _____

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

10. NAME OF FATHER LEON POTTS

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

12. MAIDEN NAME OF MOTHER ONA BLADES

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

14. INFORMANT Leon Potts
 (Address) Republic Mo

Jan- 26- 29 H.G. Frame
 FILED..... 19..... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15. DATE OF DEATH (MONTH, DAY AND YEAR) Jan-26th 19 29
 17. I HEREBY CERTIFY That I attended deceased from Jan- 1st - 19 29 to Jan- 26th - 19 29
 that I last saw h. or alive on Jan- 25th - 19 29, and that death occurred, on the date stated above, at 4.15 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia
 (duration) yrs. mos. 26 ds.
CONTRIBUTORY Meningitis
 (SECONDARY) (duration) yrs. mos. 7 ds.

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

8 DID AN OPERATION PRECEDE DEATH? No. DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? Physical signs
 (Signed) H.G. Frame, M. D.
1-26-19 29 (Address) Republic, 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Wades Chapel, Republic, Mo. DATE OF BURIAL 1-27-29 19

20. UNDERTAKER H.G. Frame ADDRESS Republic, Mo

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

PERMANENT RECORD

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