

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.

SEP 24 1930

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

Do not use this space.

26424

File No. _____
Registered No. 634
St. _____ Ward _____

1. PLACE OF DEATH
County Greene Registration District No. 918
Township Springfield Primary Registration District No. 2821
City Springfield (No. 1625 6. Florida)
2. FULL NAME Estey Marie Potter
(a) Residence No. 1625 6, Florida 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) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edd Potter
6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 4 - 1899
7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
31 5 17
8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work. At Home
(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) Mo
10. NAME OF FATHER F. L. Dellinger
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Aida M. Scholtz
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ohio
14. INFORMANT F. L. Dellinger
(Address) Springfield, Mo.
15. FILED 8/22, 1930 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 8-21-1930
17. I HEREBY CERTIFY, That I attended deceased from 8-18-1930 to 8-21-1930, that I last saw her alive on 8-21-1930, and that death occurred, on the date stated above, at 11 a. m.
THE CAUSE OF DEATH* WAS AS FOLLOWS:
Julmonary T.B.
2, 3, 4
CONTRIBUTORY (SECONDARY) (duration) 2 yrs. mos. ds.
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) C. E. Feller M. D.
8-22-1930 (Address) Springfield 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 DATE OF BURIAL
Timber Ridge Cemetery Aug 23 1930
20. UNDERTAKER 424 E. 6th St. Springfield Mo. ADDRESS

