

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

Do not use this space.

44215

JAN 29 1937

1. PLACE OF DEATH

County Franklin
Township Bohler
City Bourbon

Registration District No. 229
Primary Registration District No. 4137

File No.
Registered No.
St. Ward)

2. FULL NAME

Frank Michael Pototowicz

(a) Residence, 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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-30-1936

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

22. I HEREBY CERTIFY That I attended deceased from Dec. 27, 1936 to Dec. 30, 1936
I last saw him alive on Dec. 30, 1936 Death is said to have occurred on the date stated above, at 8 P. M.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 29-1866

The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 3 1

Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Cerebral hemorrhage - Apoplexy.
Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

13. NAME Michael Pototowicz

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

15. MAIDEN NAME Julia Broch

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Austria

17. INFORMANT Morie Pototowicz (ADDRESS) Bourbon Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Leasburg DATE 1-2-37

19. UNDERTAKER (ADDRESS) Elbert E. Long Bourbon, Mo.

20. FILED 1-2-37 C. Williams Registrar.

Name of operation clinical Date of 7/20
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19...

Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify W. J. Truman M. D.
(Signed) Leasburg Mo. (Address)

