

REC'D APR 11 1939

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

10891
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE Registration District No. 1315 944
 (b) Township Jackson Primary Registration District No. 5447 B
 (c) City Stratford Street No. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 360 Ella Bell Potter Stratford Mo. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
 4. COLOR OR RACE White
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF James F. Potter
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 6 - 1858
 7. AGE YEARS 81 MONTHS 1 DAYS 21 If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Wife
 9. Industry or business in which work was done, as saw mill, bank, etc. In home
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 27, 1939
 22. I HEREBY CERTIFY, That I attended deceased from March 24, 1939, to March 27, 1939
 I last saw her alive on March 27, 1939 Death is said to have occurred on the date stated above, at 2 P. m.
 The principal cause of death and related causes of importance were as follows:

Chronic Nephritis
 Arteriosclerosis
 Date of onset ?
 Other contributory causes of importance: ?

Name of operation _____ Date of _____
 What test confirmed diagnosis? Cholesterol Was there an autopsy? No

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? No
 No, specify _____
 (Signed) P. H. Frost M. D.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss
 13. NAME J. M. West
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 17. INFORMANT (ADDRESS) Charles Potter Stratford Mo.
 18. BURIAL, CREMATION OR REMOVAL PLACE Deaforth DATE March 31, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. Plouquet Springfield Mo.
 20. FILED Apr. 4 1939 Chas. Anderson Local Registrar.

WRITE PLAINLY, WITH UNFADING INK. THIS IS VERY IMPORTANT. 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.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.