

JAN 13 1940
Registration District No. _____

399

Primary Registration District No. **1002**

Registrar's No. _____

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.

1. PLACE OF DEATH:
(a) County JACKSON
(b) City or town KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1911 E. 24th St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community 15 yrs
years, months or days

3. (a) PRINT FULL NAME Maudie Potts 321
3. (b) If veteran, name was no
3. (c) Social Security No. none

4. Sex F. MALE
5. Color or race NEGRO
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife JESSE Potts
6. (c) Age of husband or wife if alive 57 years
7. Birth date of deceased Dec 7 1886
(Month) (Day) (Year)

8. AGE: Years 53 Months 0 Days 22
If less than one day _____ hr. _____ min.

9. Birthplace St. Joseph, Mo. Buchanan
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business _____
MOTHER FATHER {
12. Name Aaron Payne
13. Birthplace MO
14. Maiden name Irma Robinson
15. Birthplace MO

16. (a) Informant's own signature Jesse Potts
(b) Address 1911 E. 24th St.

17. (a) BURIAL (b) Date thereof Jan. 23, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Joseph, Mo.

18. (a) Signature of funeral director WEST APPLETON JONES
(b) Address 1905 Vine St.

19. (a) Dec. 31, 1939 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County JACKSON
(c) City or town KANSAS CITY
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec, day 29th, year 1939 hour 11:25 minute AM
21. I hereby certify that I attended the deceased from Dec 10, 1939, to Dec 29, 1939
that I last saw h. alive on Dec 27 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma-toxic
Due to Primary carcinoma of mammary
Due to 50

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations none
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature J.P. Jones (M. D. or other) _____
Address 1914 Vine St. Date signed 1/1/40

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

[Handwritten Signature]

Licensed Embalmer No.

2910

P. O. Address

R. C. M. O.

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.