

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33873

Registrar's No. 8570

Registration District No. _____

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 days (Specify whether
In this community Life
years, months or days)

3. (a) PRINT FULL NAME William DePotter

3. (b) If veteran, name war _____ 3. (c) Social Security No. 489-07-0969

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lily DePotter 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased. August 11, 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
60 2 4 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business Independent Packing Co.

12. Name John DePotter

13. Birthplace Unknown Hoiland
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Lily De Potter

(b) Address 3924a Nebraska

17. (a) Cremation (b) Date thereof 10/17/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri Crematory

18. (a) Signature of funeral director Walter W. W. W.

(b) Address 2331 S. Broadway

19. (a) OCT 17 1940 (b) J. B. B.
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 27
(If outside city or town limits, write "RURAL")
(d) Street No. 3924a Nebraska
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 15
year 1940 hour 4 minute 25a. M.

21. I hereby certify that I attended the deceased from June 19-40 to Oct 10/14, 1940,
that I last saw him alive on Sept 14-40, 1940,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage 3 days

Due to _____

Due to Hypertension 2

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

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) (a) Means of injury _____

23. Signature Prof. L. J. J. (M. D. or other) _____

Address 4065 Du Grand Ave Date signed 10/14/40

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.....

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.