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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 13 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30382

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 680

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2134 Prospect
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community 48 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits, write "RURAL")
(d) Street No. 2134 Prospect
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ERNEST LEE POTTS
3. (b) If veteran, name war none
3. (c) Social Security No. none
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lela Potts
6. (c) Age of husband or wife if alive 48 years
7. Birth date of deceased November (Month) 4 (Day) 1893 (Year)

8. AGE: Years 48 Months 10 Days 16 If less than one day hr. min.

9. Birthplace Greene County, (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Dairyman
11. Industry or business Farm
FATHER
12. Name Edward Lee Potts
13. Birthplace Harrison, (City, town, or county) Arkansas (State or foreign country)
MOTHER
14. Maiden name Sarah Miller
15. Birthplace Republic, (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Lela Potts
(b) Address 2134 Prospect Spfd., Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/42 (Month) (Day) (Year)
(c) Place: burial or cremation Robberson Prairie
18. (a) Signature of funeral director Fred Thieme
(b) Address Springfield, Mo.
19. (a) 9-22-42 (Date received local registrar) (b) W E Hardley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 20th year 1942 hour 9:10 minute A. M.
21. I hereby certify that I attended the deceased from Feby 2 1942, to Sept 20 1942, that I last saw him alive on Sept 20 1942, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Generalized Paralysis gradually following Operation for Brain Tumor	10 yr
Due to 10 yrs ago	
Due to	
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) Not
(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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Fred Thieme (M. D. or other)
Address Springfield Mo Date signed 9/22/42

(Licensed Embalmer's Statement on Reverse Side)

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. 3681

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

. S. No. 2B
M—8-21-41
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STANDARD CERTIFICATE OF DEATH

State File No. 30382

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 680

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County: Greene

(b) City or town: Springfield (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write "RURAL")

(d) Street No. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Ernest Lee Potts

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: M

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Nov (Month) 4 (Day) 1893 (Year)

8. AGE: Years 48 Months 10 Days If less than one day hr. min.

9. Birthplace: (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

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

14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day 20 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw him alive on 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized Paralysis gradually following operation for Brain Tumor 10 yrs ago — Duration 10 yrs.

Due to: Benign Brain Tumor

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: 56

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (c) Means of injury

23. Signature: Robert F Wellman (M.D. or other)

Address: Springfield Mo Date signed

SUPPLEMENTARY