

FILED JAN 9 1943

Registration District No. 110

Primary Registration District No. 6425

Registrar's No. 40693

1. PLACE OF DEATH: FRANKLIN

(a) County FRANKLIN

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

(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)

In this community ALL years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County FRANKLIN

(c) City or town RURAL  
(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 MRS WILHELMINE POTT

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 28  
year 1942 hour 6:30 minute P. M.

4. Sex FEMALE 5. Color or race W

6. (a) Single, widowed, married, divorced WIDOW

6. (b) Name of husband or wife JOHN POTT 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: APRIL 24 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 16, 1942 to Dec. 28, 1942  
that I last saw her alive on Dec. 28, 1942  
and that death occurred on the date and hour stated above.

8. AGE: Years 73 Months 8 Days 4  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Metastatic Carcinoma

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

Due to Uterine Carcinoma

Due to \_\_\_\_\_

10. Usual occupation HOUSE WIFE

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: H&P

MOTHER FATHER

11. Industry or business \_\_\_\_\_

12. Name FRERRICK TILKE

13. Birthplace GERMANY  
(State or foreign country)

14. Maiden name SOPHIA BYRONE

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

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Edurn Pott  
(b) Address New Haven Mo

17. (a) BURIAL (b) Date thereof 12-31-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Place: burial or cremation PORT HADSON MO

18. (a) Signature of funeral director W. H. Hartig, Son

(b) Address NEW HAVEN MO

19. (a) 12-30-42 (b) Colava England  
(Date received local registrar) (Registrar's Signature)

(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) Means of injury 2

23. Signature W. H. Hartig (M. D. or other) D.O.  
Address New Haven Mo Date signed 12/29/42

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

36  
0  
0

36  
0  
0

263

**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

*Earl J. Fresteg*

Licensed Embalmer No.

*3385*

P. O. Address

*York Haven Pa*

**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, fact should be so stated above.**