S. No. 2
M—9-4-41
5-17-39

FILED MAY 5 1943

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

13367

State File No.

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1815

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

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: Kansas City T.B. Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 24 days (Specify whether

In this community 29 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48 3

(c) City or town Kansas City 8 (If outside city or town limits, write "RURAL")

(d) Street No. 1332 Jefferson (If rural give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME John B Potter

3. (b) If veteran, name war no

3. (c) Social Security No. 459-05-0583

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced 2 Separated

6. (b) Name of husband or wife —

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

7. Birth date of deceased 5 (Month) 3 (Day) 1911 (Year)

8. AGE: Years 31 Months 11 Days 10 If less than one day hr. min.

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

10. Usual occupation Truck driver

11. Industry or business Trucking

FATHER
12. Name Robert Potter
13. Birthplace (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Susan Wheeler
15. Birthplace (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Records K.C. T.B. Hosp.

(b) Address K.C. Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-16-43 (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cem

18. (a) Signature of funeral director H. Tigerman & Son

(b) Address K.C. Mo.

19. (a) 4-16-43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 13 year 43 hour 1 - 25 minute P. M.

21. I hereby certify that I attended the deceased from 3-20-43, 19, to 4-13, 1943 that I last saw him alive on 4-13, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Perforated Tuberculosis ulcer of ileum	3 hrs.
Due to Tuberculosis Enteritis	1 mo.
Due to Pulmonary Tuberculosis	4 mo
Other conditions (Include pregnancy within 3 months of death) 13B1	

Major findings:
Of operations
Of autopsy Same

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? (Specify type of place)

While at work? (e) Means of injury —

23. Signature Matthew J. Noon (M. D. ~~or other~~)

Address K.C. T.B. Hosp. Date signed 4/14/43

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(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 Francis Walton, Registered Apprentice No. 2744 working under my personal supervision.

Signed J. K. Rigerman

Licensed Embalmer No. 2744

P. O. Address K. C. Mo.

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.