

FILED AUG 27 1943

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3584

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Causes, Mo  
(c) Name of hospital or institution Lakeside Hospital  
(d) Length of stay: In hospital or institution 6 days  
In this community 3 years

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Causes, Mo  
(d) Street No. 1807 1/2 Independence Ave  
(e) Citizen of foreign country? no

3. (a) PRINT FULL NAME Ethel Ellen Potter  
(b) If veteran, name war no  
(c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug day 19<sup>th</sup>  
year 1943 hour 4 minute 40 P.M.

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Philip Potter  
6. (c) Age of husband or wife if alive 46 years  
7. Birth date of deceased Nov 8 1898

21. I hereby certify that I attended the deceased from Aug 1 1943 to Aug 19 1943  
that I last saw her alive on Aug 19 1943  
and that death occurred on the date and hour stated above.  
Immediate cause of death adynamic ileus

8. AGE: Years 44 Months 9 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to acute glomerular nephritis  
Due to uterine fibrosis

9. Birthplace Topeka Kansas

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

10. Usual occupation at home

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

MOTHER FATHER  
11. Industry or business \_\_\_\_\_  
12. Name Sidney Johnston  
13. Birthplace England  
14. Maiden name Hettie Sophia Johnston  
15. Birthplace unknown

Major findings: uterine fibrosis, nonobstructive bilateral salpingitis  
Of operations \_\_\_\_\_  
Of autopsy none

16. (a) Informant Philip Potter  
(b) Address 1807 1/2 Independence Ave Remond  
17. (a) (Burial, cremation, or removal) Removal (b) Date thereof 8-20-43  
(c) Place: burial or cremation Topeka, Kansas  
18. (a) Signature of funeral director W. E. Brown  
(b) Address 104 W. 42nd Street  
19. (a) 8-19-43 (b) W. E. Brown

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(c) Means of injury \_\_\_\_\_  
23. Signature Margaret J. ... (at D. or other) D.O.  
Address 3639 St. R.C. Mo. Date signed 8-19-43

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**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 conform the above constitutes grounds for revocation of license.)**

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

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 3584

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

3. (a) PRINT FULL NAME Ether Ellen Potter  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 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: not (Month) 8 (Day) (Year) \_\_\_\_\_

8. AGE: Years 44 Months 9 Days \_\_\_\_\_ (Unless than one day, \_\_\_\_\_ min.)

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

10. Usual occupation \_\_\_\_\_

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

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 Salpingitis not  
(b) Address due to gonorrhea  
or prostatic  
condition

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (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)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Immediate cause of death adynamic ileus Duration \_\_\_\_\_

Due to acute glomerular nephritis

Due to uterine fibrosis

Other conditions due to acute (Include pregnancy within 6 months of death)

Major findings: uterine fibrosis (Secretary) (over)

Of operations non specific bilateral salpingitis

Of autopsy salpingitis

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 Margaret (M. D. or other) D.O.

Address 3639 W. K.C. Mo. Date signed 9-10-43

SUPPLEMENTARY

MOTHER FATHER

suppression.

Note: Autopsy performed after filing of Certificate of Death revealed kidney pathology to be that of chronic glomerulo-nephritis.

Salpingitis not due to puerperal or gonorrhoeal infection.

M. Jones

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