

S. No. 2
DM-8-43
v. 5-17-39
X37823

23380

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 11

Primary Registration District No. 4024

Registrar's No. 46

1. PLACE OF DEATH:

(a) County Barry

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

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

(d) Length of stay: In hospital or institution In Hospital 7 da.
(Specify whether life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Barry

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

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

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

If yes, name country _____

3. (a) PRINT FULL NAME William C. Potter

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 Myrtle Potter 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Jan. 9, 1878
(Month) (Day) (Year)

8. AGE: Years 67 Months 5 Days 24 If less than one day hr. _____ min. _____

9. Birthplace Barry Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER { 12. Name James Potter

13. Birthplace do not know
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Short

15. Birthplace do not know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Myrtle Potter

(b) Address Cassville, Mo.

17. (a) burial (b) Date thereof 7/4/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mc Kinney Cem.

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

(b) Address Cassville, Mo.

19. (a) July 16-1945 (b) Grace Williams
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 3 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from June 20, 1945, to July 3, 1945, that I last saw him alive on July 3, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage followed by uremia

Duration 6 wks. 3 das.

Due to _____

Due to _____

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

Major findings: Of operations gsw

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? _____

(Specify type of place) _____

While at work _____ (e) Means of injury _____

23. Signature Robert Deanna (M. D. or other) M. D.

Address Cassville, Missouri Date signed 7-11

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

1079

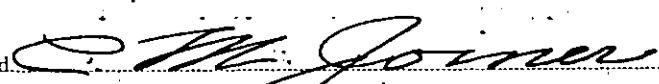
RECEIVED
District Health Officer No. 8,
District File Number 845-857
Date Filed AUG 10 1945

AUG 10 2 1945

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. 3453

P.O. Address CASSVILLE, 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.