

S. No. 2
M-8-43
5-17-39
X3782

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25620

State File No.

Registrar's No. **6578**

Registration District No.

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....
 (b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Deaconess Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution..... **4 days**
(Specify whether

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

2. USUAL RESIDENCE OF DECEASED:

(a) State..... **Missouri** (b) County..... **AUDRAIN**
 (c) City or town..... **Mexico**
(If outside city or town limits, write "RURAL")
 (d) Street No..... **Rural**
(If rural, give location)
 (e) Citizen of foreign country?..... **No** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME..... **Albert Potthoff**

3. (b) If veteran, name war..... **None**

3. (c) Social Security No..... **None**

4. Sex..... **M** 5. Color or race..... **W**

6. (a) Single, widowed, married, divorced..... **W**

6. (b) Name of husband or wife..... **Margaret**

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

7. Birth date of deceased..... **Oct 9 1875**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
70	9	16hr.min.

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

10. Usual occupation..... **Farmer**

11. Industry or business..... **self**

MOTHER FATHER

12. Name..... **Theodore Potthoff**

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

14. Maiden name..... **Unknown**

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

16. (a) Informant..... **Leonard H. Potthoff**

(b) Address..... **Ladonia, Mo. Rural**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof..... **7-29-46**
(Month) (Day) (Year)

(c) Place: burial or cremation..... **Zion Cemetery**

18. (a) Signature of funeral director..... **Baumgardner Prot. Dist. Inc.**
 (b) Address..... **2504-Woodson Rd Overland, Mo**

19. (a) **JUL 26 1946** (Date received by Registrar) (b) **J. F. Bredet** (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month **July** day **25**
 year **1946** hour **8** minute **40** P. M.

21. I hereby certify that I attended the deceased from **July 19**
 19 **46** to **July 25**, 19 **46**
 that I last saw him alive on **July 25**, 19 **46**
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
Complications of Prostate with adenocarcinoma metastases
 Due to.....
Acute myocardial infarction
 Due to.....
Polycythemia

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).....
 (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..... **J. F. Bredet** (M. D. or other)
 Address..... **103 Monument** Date signed..... **7/26/46**

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

24470

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NR

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 Oscar F Mueller
Licensed Embalmer No. 3039
P. O. Address Overland 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.