

FILED FEB 5 1947
374

Registration District No.

Primary Registration District No. 4547

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Grant 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. Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Arch Gerald Potter

3. (b) If veteran, name war. ✓

3. (c) Social Security No. ✓

4. Sex MC 5. Color or race W 6. (a) Single, widowed, married, divorced. ✓
6. (b) Name of husband or wife. ✓ 6. (c) Age of husband or wife if alive. ✓ years
7. Birth date of deceased July 29 1943 (Month) (Day) (Year)

8. AGE: Years 3 Months 6 Days 21 If less than one day hr. min.

9. Birthplace Grant city MO. (City, town, or county) (State or foreign country)

10. Usual occupation.

11. Industry or business.

12. Name Beryl Potter
13. Birthplace Worth co. MO. (City, town or county) (State or foreign country)
14. Maiden name Edna Miller
15. Birthplace Worth co. MO. (City, town, or county) (State or foreign country)

16. (a) Informant Edna Potter
(b) Address Grant city, MO.

17. (a) Burial (b) Date thereof 1-22-47 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation High Cemetery

18. (a) Signature of funeral director Frank C. Dwyer

(b) Address Grant city, MO.

19. (a) 1-24-47 (b) Teta E. Dawson (Data received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County Worth
(c) City or town Grant city (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 1 day 20
year 1947 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from November 1946, to 20 January 1947, that I last saw him alive on 20 Jan 1947, and that death occurred on the date and hour stated above.

Immediate cause of death Acute Lymphatic Leukemia Duration 1 month

Due to.

Due to.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations M4A

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 Frank D. Matheson M.D. (M. D. or other)

Address Grant City Date signed 21 Jan 47

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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.....

Arch C. Dunfee

Licensed Embalmer No. *3252*

P. O. Address.....

Grant City 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Feb

Registration District No. 924

Primary Registration District No. 4547

Registrar's No. 8

1. PLACE OF DEATH:

- (a) County Worth
(b) City or town Shantley
(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 years, months or days)

3. (a) PRINT
FULL NAME

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

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

7. Birth date of deceased
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
3 6 1 hr. min.

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

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

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1-24-47 (b) Leta E. Dawson
(Date received local registrar) (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 Feb year 1947 hour 2 minute 20 M.

21. I hereby certify that I attended the deceased from 1947 to 1947;
that I last saw him alive on July 29 and that death occurred on the date and hour stated above.
Immediate cause of death Supplementary

Due to

Due to

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 (M. D. or other)

Address Date signed

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

S-3799