

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

Registration District No. **338** Primary Registration District No. **6148** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County **Stoddard**  
(b) City or town **Idalia** (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 **75 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Stoddard 103**  
(c) City or town **Idalia** (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 \_\_\_\_\_

3. (a) PRINT FULL NAME **MARY E. POTTEYSON**  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Sept** day **12** year **1947** hour **12** minute **30 A.M.**  
21. I hereby certify that I attended the deceased from **9-8** 19**47** to **9-10** 19**47** that I last saw her alive on **9-10** 19**47** and that death occurred on the date and hour stated above.

4. Sex **FEMALE** 5. Color or race **WHITE**  
6. (a) Single, widowed, married, divorced **MARRIED**  
6. (b) Name of husband or wife **Monte Patterson** 6. (c) Age of husband or wife if alive **88** years  
7. Birth date of deceased **Sept 19 1867** (Month) (Day) (Year)

Immediate cause of death **Cerebral Hemorrhage**  
Due to **Arteriosclerosis**  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations **83A**  
Of autopsy \_\_\_\_\_  
Duration \_\_\_\_\_

8. AGE: Years **79** Months **11** Days **23** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Housewife**

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

MOTHER FATHER  
12. Name **Allen Pruitt**  
13. Birthplace **Kentucky** (City, town, or county) (State or foreign country)  
14. Maiden name **Marjory Watkins**  
15. Birthplace **Indiana** (City, town, or county) (State or foreign country)

16. (a) Informant **Mary Beckett**  
(b) Address **Idalia Mo.**

17. (a) **Burial** (b) Date thereof **Sept 12 1947** (Month) (Day) (Year)  
(c) Place: burial or cremation **Bluff Cemetery**

18. (a) Signature of funeral director **Walter James Finno**  
(b) Address **Bloomfield Mo.**

19. (a) **9-19-47** (b) **Rose Webber** (Date received local registrar) (Registrar's signature)

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 **20**  
23. Signature  **Gordon Clyntall** (M. D. or other) **DO**  
Address **Bloomfield** Date signed **9-15-47**

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

RECEIVED

District Health Office No. 2,

District File Number 947-1260

Date Filed 9-22-47

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 Lynnan Steele

Licensed Embalmer No. 2476

P. O. Address Hexter 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.**