No. 2
-1/47
-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED NOV 6 1947

Registration District No. 377

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 36697

Registrar's No. 2283

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street, number or location)

(d) Length of stay: In hospital or institution 183 days (Specify whether

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 2637a Hebert (If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Margaret Frances Pott

3. (b) If veteran, name war

3. (c) Social Security No. 498-26-9839

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Leonard Pott

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

7. Birth date of deceased October (Month) 23 (Day) 1918 (Year)

8. AGE: Years 29 Months - Days 5 If less than one day hr. min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Michael Meitz
13. Birthplace (City, town, or county) Austria (State or foreign country)

MOTHER
14. Maiden name Thekla Kimmel
15. Birthplace (City, town, or county) Austria (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-47 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cem

18. (a) Signature of funeral director Edw Koch + Son

(b) Address 3516 N. 14th - St. Louis

19. (a) 10-31-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 28 year 1947 hour 7 minute 55 P. M.

21. I hereby certify that I attended the deceased from 4-29- 1947 to 10-28- 1947 that I last saw her alive on 10-28- 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Tuberculosis	11 yrs. (??)
Due to 132	
Due to	
Other conditions (Include pregnancy within 3 months of death): Thoracoplasty, right - 2nd stage	

Major findings:
Of operations
Of autopsy

PHYSICIAN — Underline the cause of 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 [signature] (M. D. or other) M.D.

Address Robert Koch Hospital Date signed 10-29-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

JUL 27 1951

NOV 7 1947

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 Ronald Jahnke

Licensed Embalmer No. 3917

P. O. Address.....

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.