

No. 2
-12-45
-17-39
I X47070

FILED NOV 17 1947

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1348

1. PLACE OF DEATH:

(a) County St. Joseph
(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital # 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 yrs 1 mo 16 days
(Specify whether years, months or days) 5 yrs - 1 mo - 16 days

3. (a) PRINT FULL NAME Eva L. Potter

3. (b) If veteran, name war No 3. (c) Social Security No. Nil

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive 18 1/2 years
7. Birth date of deceased May 26 1879
(Month) (Day) (Year)

8. AGE: Years 72 Months 5 Days 14 If less than one day hr. min.

9. Birthplace Clinton County, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business at home

12. Name William Potter

13. Birthplace Mo

14. Maiden name MARY Anna Seaton Rhodes

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

16. (a) Informant Mrs. Ada Seaton

(b) Address Jurney, Mo

17. (a) burial (b) Date thereof Nov. 13 - 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation TURNERY MO

18. (a) Signature of funeral director De Moss CRUNK

(b) Address CAMERON MO

19. (a) 11-14-47 (b) G. B. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton
(c) City or town Jurney Mo Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural Turney
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 10
year 1947 hour 5 minute 30 P.M.

21. I hereby certify that I attended the deceased from 11-10, 1947, to 11-10, 1947
that I last saw her alive on 11-10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary tuberculosis & myocardial infarction
Due to arteriosclerosis
Duration 4 yrs
recurrent myocarditis
5 yrs +

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)
(c) Means of injury 0

23. Signature [Signature] (M. D. or equivalent)
Address State Hospital # 2 Date signed 11/10/47

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

MOTHER FATHER

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.....

Lee M. Clark

Licensed Embalmer No. *2533*

P. O. Address *Cameron MD*

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.