

FILED JUL 26 1951

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 25134  
Registrar's No. 6320

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>4 days</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Venice</u>		8120
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Anthony's Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>1207 Market St.</u>		
3. NAME OF DECEASED (Type or Print) <u>Rachel Potts</u> a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>July 13 1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>about 89</u>	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Totally blind &amp; Never did work</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Clayburn Co. Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>William Potts</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Ann Sulferage</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mary Kozahl Venice</u> ADDRESS <u>Venice, Ill.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Lt. Hip.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7/16/51</u>
19a. DATE OF OPERATION <u>7-13-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Femoral Neck fracture, left hip.</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>4200 F</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>7 10 51</u> m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Fall</u>			
22. I hereby certify that I attended the deceased from <u>7-10-51</u> , 19 <u>51</u> , to <u>7-13-51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>7-13-51</u> , 19 <u>51</u> , and that death occurred at <u>12</u> p. m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Carl M. Fellhauer M.D.</u> (Degree or title) _____			23b. ADDRESS <u>505 Humboldt Bldg St Louis Mo</u>		23c. DATE SIGNED <u>7-14-51</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>7/16/51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Alley Mc Cormick</u>	24d. LOCATION (City, town, or county) (State) <u>Alley Mo.</u>		
DATE REC'D BY LOCAL REGISTRY <u>JUL 16 1951</u>		REGISTRAR'S SIGNATURE <u>J B Foster</u>		GENERAL DIRECTOR'S SIGNATURE <u>Marion J. Sakay</u> ADDRESS <u>Madison Ill.</u>	

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

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 \_\_\_\_\_

working under my personal supervision.

Signed.....  
Student Embalmer

Signed.....

Student Embalmer No.....

Licensed Embalmer No. 2792

P. O. Address Madison Ill

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.