

Health, Welfare, Public Service

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-57

Wallace H. Graham
MEDICAL CERTIFICATION
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 30 1957

28326
STATE FILE NUMBER
3752

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3752

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Research Hosp.</u>			Length of stay in lb <u>30 yrs.</u>		d. STREET ADDRESS (If outside, give location) <u>5500 Troost</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>H.</u> Last <u>Potter</u>				4. DATE OF DEATH Month <u>August</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>December 1, 1906</u>		9. AGE (In years last birthday) <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Osteopathic Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		11. BIRTHPLACE (City and state or country) <u>Petersburg ILL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John L. Potter</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>DR. M. Young</u>		Address <u>5500 TROOST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver and Renal Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 Months</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cirrhosis of liver (Bant's Syndrome)</u>						Years <u>280</u>	
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): <u>Umbilical Hernia with Strangulated, gangrenous bowel - Resected</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>26 July - 57</u> to <u>9 Aug 1957</u> and last saw ^{her} _{him} alive on <u>9 Aug. 1957</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Wallace H. Graham, M.D.</u> (Degree or title)				22b. ADDRESS <u>518 Argyle, K.C., Mo.</u>		22c. DATE SIGNED <u>10 Aug. 57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>August 11, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Petersburg Illinois</u>		
24. FUNERAL DIRECTOR <u>Muehlebach</u>		ADDRESS <u>6500 Troost</u>		25. DATE RECD. BY LOCAL REG. <u>8-10-57</u>		26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)



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 Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *R. L. Nichols*

Licensed Embalmer No. *4997*

P. O. Address *4500 Transit*

K.C. 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.