

THE DIVISION OF HEALTH OF MISSOURI  
**FILED SEP 11 1957 STANDARD CERTIFICATE OF DEATH**

State File No. **30464**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **2129**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>St. Louis</b> b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>Normandy</b> c. LENGTH OF STAY (in this place) <b>15 days</b> d. FULL NAME OF HOSPITAL OR INSTITUTION <b>43 Normandy Osteopathic Hosp. 2910</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission). --a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b> c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> * STREET ADDRESS (If rural, give location) <b>1124 E. LINTON AVE.</b>	
<b>3. NAME OF DECEASED</b> (Type or Print) a. (First) <b>Nellie</b> b. (Middle) <b>MAY</b> c. (Last) <b>Potterfield</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>August 24 1957</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED/ NEVER MARRIED, WIDOWED, DIVORCED (Specify)</b> <b>married</b>	<b>8. DATE OF BIRTH</b> <b>July 12, 1886</b>
<b>9. AGE</b> (In years last birthday) <b>71</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 14 HRS. Hours _____ Min. _____	<b>11. BIRTHPLACE</b> (City and State or Foreign Country) <b>St. Louis, Missouri</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		<b>13a. FATHER'S NAME</b> <b>HENRY GETTMANN</b>	
<b>13b. MOTHER'S NAME</b> <b>LENA GETTEMANN</b>		<b>13c. NAME OF HUSBAND OR WIFE</b> <b>HOWARD L. POTTERFIELD</b>	

<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>	<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> <b>Mrs. Evelyn Scholla</b>	<b>18. ADDRESS</b> <b>8946 Whitestone</b>
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<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	<b>MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
	<b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)</b> <b>Cerebral Hemorrhage (CVA)</b>		<b>1 yr</b>  <b>5 yr</b>
	<b>ANTECEDENT CAUSES</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Atheroma</b>			
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			

<b>19a. DATE OF OPERATION</b>	<b>19b. MAJOR FINDINGS OF OPERATION</b>	<b>20. AUTOPSY?</b> <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify)	<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <b>3318</b>
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b>

**22. I hereby certify that** attended the deceased from **Jan 1954** to **Aug 1957**, that I last saw the deceased alive on **8/24/57**, 19**57**, and that death occurred at **11:40 P.M.**, from the causes and on the date stated above.

**23a. SIGNATURE** **W. H. Kiesler, D.O.** (Degree or title) **5004 No. Blwy** **8/24/57**  
**23b. ADDRESS** **5004 No. Blwy**  
**23c. DATE SIGNED** **8/24/57**

**24a. BURIAL, CREMATION, REMOVAL (Specify)** **Burial**  
**24b. DATE** **8-27-57**  
**24c. NAME OF CEMETERY OR CREMATORY** **ST. PETERS CEMETERY**  
**24d. LOCATION (City, town, or county) (State)** **ST. LOUIS COUNTY - Mo.**

**DATE REC'D BY LOCAL REG.** **8-26-57**  
**REGISTRAR'S SIGNATURE** **Hubert B. Donohue M.D.**  
**25. FUNERAL DIRECTOR'S SIGNATURE** **CALVIN F. FEUTZ**  
**ADDRESS** **4828 Natural Bridge Blvd., St. Louis, 15, Mo.**

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

No. 300  
10-48

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 *John A. Mlinar*.....  
Licensed Embalmer No. *418*

P. O. Address *St. Louis*

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.