

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035808

STATE FILE NUMBER

FILED OCT 27 1958

Registration District No. 72 Primary Registration District No. 3013 Registrar's No. 134

300
1-57

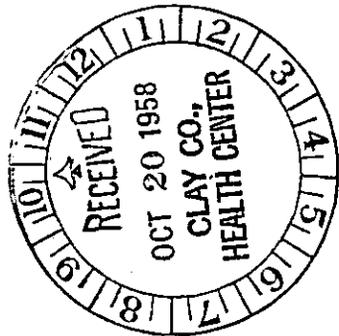
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North 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>Memorial Hosp.</u>		Length of stay in lb <u>3 days</u>	d. STREET (If outside, give location) ADDRESS <u>5008 4522 Kelsey, Rd</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rhilda JUANITA POTREE</u>			4. DATE OF DEATH Month Day Year <u>OCT. 15, 1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 27, 1920</u>
9. AGE (In years last birthday) <u>38</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Switchboard operator, Western</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u>	11. BIRTHPLACE (City and state or country) <u>St. Clair Co. Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>LOBANE, Bellew</u>	
13b. MOTHER'S MAIDEN NAME <u>Hazel WARD</u>		14. NAME OF HUSBAND OR WIFE <u>Charles P. Potree</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>494-16-7344</u>	
17. INFORMANT <u>H.A. ANDERSON, 3720 Oak Blvd</u>		Address <u>Calif.</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>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>251X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>2 mo Post op. day Thrombolectomy (non toxic)</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. Month, Day, Year			
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,actory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>10-16-58</u> <u>deceased</u> and last saw her/him alive on <u>10-15-58</u> Death occurred at <u>9:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>R. Fulenham M.D.</u>		22b. ADDRESS <u>Northc. Mo -</u>	
22c. DATE SIGNED <u>10/16/58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-18-58</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>White Chapel</u>		23d. LOCATION (City, town, or county) (State) <u>Cladstone Mo</u>	
24. FUNERAL DIRECTOR <u>Dwight Newcomer N.C.</u>		25. DATE RECD. BY LOCAL REG. <u>10-17-58</u>	
26. REGISTRAR'S SIGNATURE <u>Marguerite Anderson</u>			

Dr. Dunham

OCT 2



DEC 19 1958

SEP 28 1959

STATEMENT BY LICENSED EMBALMER

VS 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 *Glen A Hill*

Licensed Embalmer No. *4586*

P. O. Address *K.C. 16.12*

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.