

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-035984
STATE FILE NUMBER

12-489-58
NOV 10 1958
Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 275

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <input checked="" type="checkbox"/> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN WASHINGTON		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <input checked="" type="checkbox"/> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL		Length of stay in 1b 4 days	036 ^{1/2} STREET ADDRESS <input checked="" type="checkbox"/> (If outside, give location) <input checked="" type="checkbox"/> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First DUANE Middle Edward Last POTTS			4. DATE OF DEATH Month OCT Day 31 Year 1958		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-27-1958	9. AGE (In years last birthday) 4	IF UNDER 1 YEAR Months 4 Days - Hours - Min. -	IF UNDER 24 HRS. Hours - Min. -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <input checked="" type="checkbox"/>	10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	11. BIRTHPLACE (City and state or country) WASHINGTON Mo 0	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Robert W. Potts	13b. MOTHER'S MAIDEN NAME Shirley Kohlbusch	14. NAME OF HUSBAND OR WIFE <input checked="" type="checkbox"/>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Robert W. Potts Address LEBANON Mo
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 7600		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.		
20d. INJURY OCCURRED WHILE AT <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 **OCT 27** to **OCT 31** and last saw her/him alive on **OCT 31**
Death occurred at **9:15 P** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) George M. Workman M.D.	22b. ADDRESS HERMANN, MO	22c. DATE SIGNED 11-1-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/2/58	23c. NAME OF CEMETERY OR CREMATORY ST-GEORGE CEMETERY	23d. LOCATION (City, town, or county) (State) HERMANN Mo
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24. FUNERAL DIRECTOR HUGO H. BLUMER ADDRESS HERMANN Mo	25. DATE RCBD, BY LOCAL REG. 11/2/58	26. REGISTRAR'S SIGNATURE J.R. Schumann
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

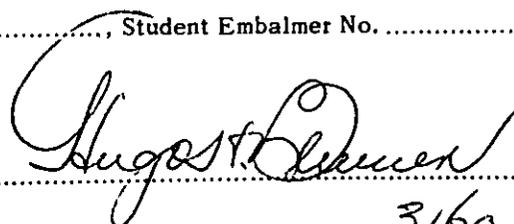
All diseases in Part I must be causally related.

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



Licensed Embalmer No. 3160

P. O. Address Hernando, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.