

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH58-038696
State File No.

FILED NOV 10 1958

BIRTH NO.		REG. DIST. NO. <u>374</u>		PRIMARY REG. DIST. NO. <u>4547</u>		Registrar's No. <u>39</u>	
1. PLACE OF DEATH a. COUNTY <u>Worth</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>Worth</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR <u>Grant City</u> <u>4547</u>		c. LENGTH OF STAY (in this place) <u>5 yrs</u>		c. CITY OR TOWN <u>Grant City</u>		d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐	
d. FULL NAME OF HOSPITAL OR INSTITUTION				f. STREET ADDRESS <u>1130</u> (If rural, give location) <u>0</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Charley</u>		b. (Middle) <u>S Aurther</u>		c. (Last) <u>Pottorff</u>	
4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 22, 1958</u>							
5. SEX <u>Male</u> <u>0</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u> <u>3</u>		8. DATE OF BIRTH <u>1972</u> <u>Jan. 23, 1868</u>	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm and General</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Hatfield, Missouri</u> <u>0</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13a. FATHER'S NAME <u>Samuel Pottorff</u>		13b. MOTHER'S MAIDEN NAME <u>Corintha Kinder</u>		14. NAME OF HUSBAND OR WIFE <u>Eda Pottorff</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'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mary Scott - Grant City, Missouri</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, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hodgkin's Disease</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>Biopsy Hodgkins Disease</u>				20. AUTOPSY? <u>2</u> YES ☐ NO ☒	
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>201X</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <u>11-3-1958</u>		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from _____, 19 <u>50</u> to <u>Oct 22</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Oct 22</u> , 19 <u>58</u> , and that death occurred at <u>3a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Frank B Matteson M.D.</u> (Degree or title) <u>0</u>				23b. ADDRESS <u>Grant City, Mo</u>		23c. DATE SIGNED <u>10-22-58</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>10-24-1958</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Mt. Ayr, Iowa</u>	
DATE REC'D BY LOCAL REG. <u>11-3-1958</u>		REGISTRAR'S SIGNATURE <u>Leta E. Dawson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bill A. Dunfee - Grant City, Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Bill A. Dwyer

Licensed Embalmer No. 490

P. O. Address Grant

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.