

Health,
Welfare
Public
Service

FILED MAR 27 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011286

STATE FILE NUMBER

2 2598

Registration District No. Primary Registration District No.

Registration No.

300
-57
92
6

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS | | c. CITY OR TOWN ST. LOUIS | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4512 WEST PINE | | d. STREET ADDRESS (If outside, give location) 1521 VAIL PL. | |
| Length of stay in lb | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last ANNIE B POTTER | | | 4. DATE OF DEATH Month Day Year MAR 12 1959 | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APRIL 4 1874 | | 9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min. 84 | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (City and state or country) ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY? U-S-A | |
| 13a. FATHER'S NAME BERNARD BUEHLER | | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 14. NAME OF HUSBAND OR WIFE FRED POTTER (DEC'D) | | |

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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 Address JOSEPH BUEHLER 1521 VAIL PL | |
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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) Myocardial Infarction | | INTERVAL BETWEEN ONSET AND DEATH 1 day |
| DUE TO (b) Arteriosclerosis Heart Disease | | |
| DUE TO (c) 420.0 | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I Arteriosclerosis F. neuropath. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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 Month, Day, Year 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 |

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| 21. I attended the deceased from 1-15-59 to 3-12-59 and last saw her alive on 3-3-59 Death occurred at 3-12-59 5 A. m on the date stated above; and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE (Degree or title) Marvin Freeman M.D. | 22b. ADDRESS 100 N. Euclid | 22c. DATE SIGNED 3-13-59 |

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|---------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | 23b. DATE MAR 14 1959 | 23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY | 23d. LOCATION (City, town, or country) (State) ST. LOUIS MO |
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| 24. FUNERAL DIRECTOR Thomas Kuttis 2906 Gravois | 25. DATE RECD. BY LOCAL REG. MAR 13 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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(Licensed Embalmer's Statement on Reverse Side)

m8c

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1-5 '72

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 James C. Hill

Licensed Embalmer No. 4347
P. O. Address 2906 Drava

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.