

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

# 59-024254

FILED VS JUL 20 1959 42

Registration District No. \_\_\_\_\_ Primary Registration District No. 1000 Registrar's No. 723

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Length of stay in 1b <b>4 Yrs</b>	c. CITY OR TOWN <b>St. Joseph,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Meth. Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location) <b>7010 Marie</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Nineva</b> Middle <b>Earl</b> Last <b>Pottorff</b>			4. DATE OF DEATH Month <b>July</b> Day <b>13,</b> Year <b>1959</b>		
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1890</b>	9. AGE (last birthday) <b>69</b>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Re. Night Watchman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Armour &amp; Co</b>	11. BIRTHPLACE (City and state or country) <b>Hatfield, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>William H. Pottorff</b>	13b. MOTHER'S MAIDEN NAME <b>Laura L. Austin</b>	14. NAME OF HUSBAND OR WIFE <b>Flotia May Pottorff</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT <b>Clarence J. Pottorff</b> Address <b>St. Joseph</b>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b>		<b>3 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Hypertensive Heart Disease</b>	<b>6 yrs</b>
	DUE TO (c) <b>Essential Hypertension</b>	<b>6 yrs</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____
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21. I attended the deceased from **March 27, 1953** to **7/13/59** and last saw him alive on **7/13/59**  
Death occurred at **11:55 PM** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Sharon E. Waggoner M.D.</b>	22b. ADDRESS <b>301 Illinois Ave St. Joseph, Missouri</b>	22c. DATE SIGNED <b>7/15/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>7/17/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Joseph, Mo</b>
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24. FUNERAL DIRECTOR <b>John E. Ruff</b> ADDRESS <b>St. Joseph, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>July 17, 1959</b>	26. REGISTRAR'S SIGNATURE <b>Mrs. Clark Goodell</b>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF S. E. WAGGONER, M.D. MEDICAL CERTIFICATION

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

~~or by~~ \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*John E. Joseph*

Licensed Embalmer No. 398

P. O. Address St. Joseph

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.