

**JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-033818**

**FILED VS OCT 3 1960**

38

Primary Registration District No. 3006

Registrar's No. 554

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Length of stay in lb <u>3 1/2 yrs.</u>		c. CITY OR TOWN <u>Columbia</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>Boone County Hospital</u>				d. STREET ADDRESS (If outside, give location) <u>808 Washington Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Hendrex</u> Last <u>Potts</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</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>July 11, 1893</u>	9. AGE (last birthday) <u>67</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HR Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Religion</u>		11. BIRTHPLACE (City and state or country) <u>Lexington, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>William Potts</u>			13b. MOTHER'S MAIDEN NAME <u>Annie Richardson</u>		14. NAME OF HUSBAND OR WIFE <u>Georgia Potts</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>414-01-2446</u>		17. INFORMANT Address <u>Mrs. Georgia Potts Columbia, Mo</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>Pneumonia, Rt. lower lobe</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Bronchial obstruction</u>						<u>1 wk</u>	
DUE TO (c) <u>Bronchogenic Carcinoma, Rt</u>						<u>9 mos.</u>	
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	
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.)					
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, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>January 1960</u> to <u>Sept 28 1960</u> and last saw her/him alive on <u>28 Sept 1960</u> Death occurred at <u>1:45</u> P on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>James Cunningham MD</u>				22b. ADDRESS <u>1009 Cherry, Columbia Mo.</u>		22c. DATE SIGNED <u>30 Sept 60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10/1/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia</u>		23d. LOCATION (City, town, or county) (State) <u>Jackson, Iowa.</u>		
24. FUNERAL DIRECTOR <u>Lyman Sprinkle</u>			ADDRESS <u>Columbia Mo</u>		25. DATE RECD. BY LOCAL AFG. <u>Oct 1 1960</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. R.E. Palmer</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Please seal  
after signing  
you - *inserted from name*

**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 *George T. [unclear]*

Licensed Embalmer No. 7425

P. O. Address Columbia

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.