

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-068193

AMENDED

Registration District No. 99 Primary Registration District No. _____ Registrar's No. 19 STATE FILE NUMBER

FILED MAR 28 1961

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Santa Rosa</u>		Length of stay in 1b <u>Life</u>	c. CITY OR TOWN <u>Santa Rosa</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>at home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARENCE C. POTTER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 19 1961</u>
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</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>Feb 18 1892</u>
9. AGE (last birthday) <u>78</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer DeKalb Co, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>
11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY	
13a. FATHER'S NAME <u>Tom Potter</u>		13b. MOTHER'S MAIDEN NAME <u>Elyzabeth Jones</u>	
14. NAME OF HUSBAND OR WIFE <u>Mr C. E. Potter</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr C. E. Potter</u>		17. INFORMANT Address <u>Santa Rosa 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>Coronary occlusion</u> DUE TO (b) <u>Cardiac enlargement, arterial sclerosis</u> DUE TO (c) <u>Chronic nephritis, prostate enlargement</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</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 Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>June 1/59</u> to <u>Mar 19-61</u> and last saw <u>him</u> live on <u>Mar 19-61</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>HW Bailey</u> (Degree or title)		22b. ADDRESS <u>Gallatin Mo</u>	22c. DATE SIGNED
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>26 Mar 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Faunt</u>	23d. LOCATION (City, town or county) (State) <u>Faunt Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>W. Johnson Pattonburg Mo</u>		25. DATE RECD. BY LOCAL REG. <u>3-25-61</u>	26. REGISTRAR'S SIGNATURE <u>Gertrude E. Davidson</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 *J. H. Johnson*

Licensed Embalmer No. 5075

P. O. Address *Parkway, 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.