

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

4865

1. PLACE OF DEATH

County Jackson
Township Raw
City Kansas City, Mo. No. 2647

Registration District No. 399
Primary Registration District No. 1003

File No. 510
Registered No. 510
St. Jackson Ward

2. FULL NAME

Kate Jackson Potter
(a) Residence No. 2647 Jackson St. 14 Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX X 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND or (OR) WIFE OF William Potter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 23 1851

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
78 4 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer -

9. BIRTHPLACE (CITY OR TOWN) Farmersville
(STATE OR COUNTRY) Ohio

10. NAME OF FATHER William Reimer

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) unknown
(STATE OR COUNTRY)

14. INFORMANT Mrs Lillian Gano
(Address) 2647 Jackson

15. FILED 7/3 19 30 M. M. Brown
REGISTRAR AM

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb, 3 1930
17.

I HEREBY CERTIFY That I attended deceased from Nov 28, 1929, to Feb, 3, 1930
that I last saw her alive on Feb, 2, 1930, and that death occurred, on the date stated above, at 12:30 m. PM

THE CAUSE OF DEATH* WAS AS FOLLOWS:

92A
37 Aortic Insufficiency
Valvular Disease (duration) 2 yrs. mos. da.

CONTRIBUTORY (SECONDARY) Aortic Sclerosis
(duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED POW
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF no
WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS
(Signed) M. M. Brown M. D.

73, 1930 (Address) 622 Shubert Bldg R.R. Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Cherrybox Mo DATE OF BURIAL Feb 8 1930

20. UNDERTAKER Kettellie ADDRESS K.C. Mo

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PRINTING WITH UNFADING INK—THIS IS A PERMANENT RECORD

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