

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

4-15
-39
447070

FILED FEB 26 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **788**

1. PLACE OF DEATH:

(a) County.....

(b) City or town..... **St. Louis, Missouri.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital - Max C. Starkloff Memorial
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. **2 days** (Specify whether newborn) (Yes or No)

In this community..... **newborn**
years, months or days)

3. (a) PRINT FULL NAME **JOHN POTTAHAST**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased. **December 13th, 1946**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

2 hr. min.

9. Birthplace. **Booth Memorial Hospital**
(City, town, or county) (State or foreign country)

10. Usual occupation. **Nil**

MOTHER FATHER

11. Industry or business.....

12. Name..... **Unknown**

13. Birthplace..... (City, town, or county) (State or foreign country)

14. Maiden name..... **Violet Pottahast**

15. Birthplace..... **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **M. Renard**

(b) Address **St. Louis City Hospital**

17. (a) **Bureau** (b) Date thereof. **1 23 47**
(Month) (Day) (Year)

(c) Place of burial or cremation **Anatomical Board of City Crematory**

18. (a) Signature of funeral director **W. Reicher** (Specify type of place) **350 Rutger**
(b) Address **City Hospital** (c) Means of injury.....

19. (a) **JAN 23 1947** (b) **J. F. Bredeck** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....

(c) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL")

(d) Street No. **Booth Memorial Hospital**
3740 Washington Ave

(e) Citizen of foreign country? **yes** (Yes or No)

If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **15th**
year **1946** hour **2:35** minute **P** M.

21. I hereby certify that I attended the deceased from **12/13/46**
19..... to **Dec. 15th** 19 **46**

that I last saw him alive on **Dec. 15th** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Diarrhea** Duration

Due to.....

Due to..... **119**

Other conditions: **dehydration**
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations.....

Of autopsy **Peritonitis**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

23. Signature **J. F. Bredeck** (M. D. or other) **J. F. Bredeck**
Address **3515 Lafayette** Date signed **12-17-46**

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.