

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

National Office of Vital Statistics  
**FILED JAN 3 1949**

Registration District No. **2**

Primary Registration District No. **4009**

1. PLACE OF DEATH:

(a) County **Andrew**  
(b) City or town **SAVANNAH**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution: \_\_\_\_\_ (Specify whether years, months or days)

3. (a) PRINT FULL NAME

**William Henry Potts**

(b) If veteran, name war: **WAR I**

(c) Social Security No. \_\_\_\_\_

4. Sex: **M**

5. Color or race: **W**

6. (a) Single, widowed, married, divorced: **S**

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

7. Birth date of deceased: **Dec 5-1890**  
(Month) (Day) (Year)

8. AGE: Years **58** Months **0** Days **14** If less than one day: \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: **NO DAWAY CO MO**  
(City, town, or county) (State or foreign country)

10. Usual occupation: **FARMER**

11. Industry or business:

12. Name: **WILLIAM FRANCES POTT**

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

14. Maiden name: **EVA MESSICK**

15. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Della Patterson Savannah Mo**  
(b) Address: **Burial**

17. (a) (Burial, cremation, or removal) **Burial** (b) Date thereof: **12-26-48**  
(Month) (Day) (Year)

(c) Place: burial or cremation: **Hillman, Mo.**

18. (a) Signature of funeral director: **E. C. Greif**  
(b) Address: **Savannah Mo**

19. (a) **12-26-48** (b) **William Sparks**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **MISSOURI** (b) County: **Andrew**  
(c) City or town: **SAVANNAH**  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country: \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **12** day **21**  
year **1948** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from **12-21-48**  
\_\_\_\_\_, 19\_\_\_\_, to **12-21**, 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary occlusion**  
Duration: **Inclad.**

Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: **941W**  
Of operations: \_\_\_\_\_

Of autopsy: **Ant Coronary Thrombosis**

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
23. Signature: **Wilbur B. Kelly** M. D. or other \_\_\_\_\_  
Address: **Savannah, Mo.** Date signed: **12-22-48**

PHYSICIAN  
Underline the cause of which death should be charged statistically.

JAN 11 1949

OCT 20 1949

---

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah mo

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.

2B  
3-45  
K43883

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Jan  
Registrar's No. 290

Registration District No. 2

Primary Registration District No. 4009

1. PLACE OF DEATH:

(a) County Andrew

(b) City or town Summerville  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Wm H. Petts

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex m

5. Color or race w

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: see 51  
(Month) (Day) (Year)

8. AGE: Years 58 Months 0 Day \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 12-18-48 (b) Lillian Sparks  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: \_\_\_\_\_ Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

39254