

FILED JUL 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

209-17-

State File No. 23219

BIRTH NO. _____ REG. DIST. NO. 113 PRIMARY REG. DIST. NO. 5430 Registrar's No. 29

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-CENTRAL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN RURAL-CENTRAL	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) a. (First) HARRY		b. (Middle) E	
c. (Last) POTTER		4. DATE OF DEATH (Month) (Day) (Year) JULY 14, 1950	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 14, 1885
9. AGE (In years last birthday) 65		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY W.H.O. GROCERY	11. BIRTHPLACE (State or foreign country) VINCENNES IND
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME JOHN T POTTER		13b. MOTHER'S MAIDEN NAME IDA COLEMAN	
14. NAME OF HUSBAND OR WIFE ALICE POTTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME ADDRESS ALICE POTTER ST. CLAIR MO			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis. 12/47-	
		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		4201	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 7-14, 1950 and that death occurred at 2:29 m., from the causes and on the date stated above.			
23a. SIGNATURE W. E. Kitchell		23b. ADDRESS St. Clair Mo	
23c. DATE SIGNED 7/14-50			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 7-15-50	
24c. NAME OF CEMETERY OR CREMATORY VINCINNES IND		24d. LOCATION (City, town, or county) (State)	
25. FUNERAL DIRECTOR'S SIGNATURE L. Worthington		ADDRESS ST. CLAIR MO	

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

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 _____

Frank R. Amaleng

Student Embalmer No. *364*

working under my personal supervision.

Frank R. Amaleng
Student
Student Embalmer

Signed *K. M. Leroy*

Licensed Embalmer No. *3606*

P. O. Address *H. Clin, 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.