

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 7 1957

STATE FILE NUMBER **19484**  
**4416**

Registration District No. **318** Primary Registration District **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Louis</u> ✓			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Richmond Heights</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>Deaconess Hospital</u>		Length of stay in lb <u>1 week</u>	d. STREET ADDRESS <u>6314 Clayton Rd.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Opal</u> Middle <u>Potter</u> Last <u>Wylie</u>			4. DATE OF DEATH <u>May 8, 1957</u>			
5. SEX <u>F</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>March 27, 1895</u>	9. AGE (In years last birthday) <u>62 yrs</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Kearney, Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anson Potter</u>			14. MOTHER'S MAIDEN NAME <u>Amanda Housh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mr. Allister Wylie 6314 Clayton Rd.</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>CARDIAC TAMPONADE.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						
DUE TO (b) <u>RUPTURE OF MYOCARDIUM</u>					<u>2 DAYS</u>	
DUE TO (c) <u>ACUTE MYOCARDIAL INFARCTION</u>					<u>9 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE. 420.1</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 _____ a. m. _____ p. m. _____						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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>August 14, 1953</u> to <u>May 8, 1957</u> and last saw <sup>her</sup> <del>him</del> alive on <u>5-8-57</u> . Death occurred at <u>9:50</u> A. m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Robert E. Koch, M.D.</u> (Degree or title)			22b. ADDRESS <u>35 N. Central, Clayton 5, Mo.</u>		22c. DATE SIGNED <u>5-8-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>May 10, 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sullivan, Ill.</u>			
24. FUNERAL DIRECTOR <u>Alexander &amp; Sons,</u> ADDRESS <u>6175 Delmar Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 8 '57</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Robert E. Koch 1-5 PM  
35 N Central  
Pa 59656

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 *Joe E. McCulloch*

Licensed Embalmer No. *24*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.