Health, Welfare Public Service

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FILED MAR 3 - 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-005782
STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 681

1. PLACE OF DEATH
a. COUNTY: JACKSON
b. CITY OR TOWN: KANSAS CITY — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: VA HOSPITAL — Length of stay in Hospital: 138 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: ST. CLAIR
c. CITY OR TOWN: ROSCOE — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): NONE — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First JOHN Middle LESLIE Last POTTER

4. DATE OF DEATH: Month February Day 9 Year 1958

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 11, 1895
9. AGE (In years last birthday): 62 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): OSCEOLA, MISSOURI
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: John M. Potter
13b. MOTHER'S MAIDEN NAME: Martha Jane Williams
14. NAME OF HUSBAND OR WIFE: Marie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 488-26-6407
17. INFORMANT: Official Records, VA Hospital, K.C., Mo. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b):
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
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 September 24, 1957 to February 9, 1958 and last saw him alive on
Death occurred at 3:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Mario Rosa (Degree or title): M.D.
22b. ADDRESS: VA Hospital, K.C., Mo.
22c. DATE SIGNED: 2-9-58

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: FEB. 9. 1958
23c. NAME OF CEMETERY OR CREMATORY: —
23d. LOCATION (City, town, or county): OSCEOLA (State): MISSOURI

24. FUNERAL DIRECTOR: D.W. NEWCOMER'S SONS. ADDRESS: KANSAS City Mo.
25. DATE RECD. BY LOCAL REG.: 2-9-58
26. REGISTRAR'S SIGNATURE: Neva Minshall

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be accepted. All diseases in Part I must be causally related.

Mario Rosa

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 ..... Signed Chester K Brown
Signature of Student Embalmer

Licensed Embalmer No. 4931

P. O. Address K C 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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