

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. OCT 3 1960 149

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Primary Registration District No. 1002 Registrar's No.

47560-034976 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>JACKSON Clay</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KAN. CITY - MISSOURI</b>		Length of stay in 1b <b>6 YEARS</b>		c. CITY OR TOWN <b>N.K.C. Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NEWBERRY NURSING Home</b>				d. STREET ADDRESS (If outside, give location) <b>2708 CHARLOTTE</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CATHERINE L. POTTER</b>				4. DATE OF DEATH Month Day Year <b>9 - 18 - 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 1878</b>	
9. AGE (last birthday) <b>82</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (City and state or country) <b>LEXINGTON, MO</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13a. FATHER'S NAME <b>William HALE</b>			13b. MOTHER'S MAIDEN NAME <b>KATHRYN LOWRY</b>			14. NAME OF HUSBAND OR WIFE <b>NEWTON Potter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MARY E Kinchelee, 332 E. 31st N.K.C. Mo</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT CEREBRAL ARTERY THROMBOSIS</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							<b>10 YRS.</b>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>INANITION. BED-RIDDEN INVALID</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m. Month, Day, Year							
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 <b>MAR 1960</b> to <b>SEPT 18, 1960</b> and last saw her <sup>him</sup> alive on <b>SEPT 15, 1960</b> Death occurred at <b>5:30</b> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>James W. Fowler, MD.</b> (Degree or title)				22b. ADDRESS <b>1103 GRAND AVE. KANSAS CITY, MO.</b>		22c. DATE SIGNED <b>9-19-60</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>9-20-60</b>		<b>Machpelah Cem</b>		<b>LEXINGTON, MO.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>D.W. NEWCOMB &amp; SONS N.K.C. Mo</b>				25. DATE RECD. BY LOCAL REG. <b>9-19-60</b>		26. REGISTRAR'S SIGNATURE <b>H.L. Dwyer</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

James W. Fowler

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John H. Henick

Licensed Embalmer No. 4848

P. O. Address 15617

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