

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041930

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **818**

Primary-Registration District No. **1003**

Registrar's No. **10897**

FILE NOV 15 1963

VS 300  
Rev. 4/59

1  
2 **2239**  
3  
4 **0**  
5 **1**  
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8 **1**  
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11  
12 **75-0**  
13

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. # 1.</b>		d. STREET ADDRESS (If outside, give location) <b>2815a Park</b>	
3. NAME OF DECEASED (Type or print) <b>RUSSELL</b> First <b>POTTS</b> Middle Last		4. DATE OF DEATH Month <b>11</b> Day <b>1</b> Year <b>1963</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/14</b>
9. AGE (last birthday) <b>49</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Produce Handler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lombardo Prod. Co.</b>	
11. BIRTHPLACE (City and state or country) <b>Bertrand Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Gary Potts</b>		13b. MOTHER'S MAIDEN NAME <b>Bertha Daniel</b>	
14. NAME OF HUSBAND OR WIFE <b>Leona Potts</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or date) <b>No</b>	
16. SOCIAL SECURITY NO. <b>7534</b>		17. INFORMANT <b>Leona Potts 2815a Park</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>SUBARACHNOID HEMORRHAGE</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			<b>330 X</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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 _____ 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>10/30/63</b> to <b>11/1/63</b> and last saw her/him alive on <b>11/1/63</b>		Death occurred at <b>4:15 P.</b> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Describe or title) <b>Donald K. Beck, M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>11/1/63</b>		22d. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>Nov. 4, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>
24. FUNERAL DIRECTOR <b>Thomas Kuttis 2906 Francis</b>	25. DATE RECD. BY LOCAL REG. <b>11-4-1963</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

USE BLACK INK OR TYPEWRITER RIBBON

**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

*J. G. Humphrey*

Licensed Embalmer No. 4772

P. O. Address

2906 Gravois

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.