Love

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

13280

File No. 23

Registered No.

1. PLACE OF DEATH

67 County Mississippi

Township Wolf Island

City Wolf Island (No. ..... St. ..... Ward)

Registration District No. 566

Primary Registration District No. 5762

2. FULL NAME John E. Botter

(a) Residence. No. ..... St., ... Ward. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Kate Botter

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 1849

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
82	5		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Germany
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER Botter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT M M Botter
(Address) Wolf Island Mo

15. Filed 18th 1932 F S Dimon REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/17/32 19.

17. I HEREBY CERTIFY, That I attended deceased from 12/1, 1931, to 4/17, 1932 that I last saw him alive on 12/16, 1931, and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

1.1

936 (duration) 10 or more yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Arteno-Sclerosis & Myocarditis

(duration) 2 or more yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) W. S. Love, M. D.

4/18, 1932 (Address) Charleston Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: S.O.O.F. Cemetery

DATE OF BURIAL: 4/18 1932

20. UNDERTAKER: The Lair Fur Co. F. D. Lair

ADDRESS: Charleston Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAY 26 1932