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

Do not use this space.

File No. 1816

Registered No. 64

1. PLACE OF DEATH

County Lynn

Township Parson Creek

City Meadville (No. ..... St. ..... Ward)

Registration District No. 603

Primary Registration District No. 1306

2. FULL NAME James Thomas Botts

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

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

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

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

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar. 14, 1867

7. AGE: Years 66 | Months 10 | Days 11 | If LESS than 1 day, ..... hrs. or ..... min.

8. OCCUPATION OF DECEASED

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

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

(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Eversonville Mo.

10. NAME OF FATHER Madison Botts

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

MAIDEN NAME OF MOTHER Henrietta Turner

BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

INFORMANT Isaac Botts
(Address) Meadville Mo.

FILED 1-25 1934 E. J. Weir
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 25, 1934

17. I HEREBY CERTIFY, That I attended deceased from Jan 4, 1934, to Jan 25, 1934, that I last saw him alive on Jan 25, 1934, and that death occurred, on the date stated above, at 12-30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer of Pelvic Tissues
Albumin Food Poisoning
Rotten Bright's Disease (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED .....

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Clinical

(Signed) E. J. Weir, M. D.

Jan 25, 1934 (Address) Meadville Mo.

*State the DISEASE CAUSING DEATH, or if death is from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Meadville Mo.

DATE OF BURIAL: Jan 27, 1934

20. UNDERTAKER: Smiley Bros

ADDRESS: Meadville

#2 Linn

**DEPARTMENT OF COMMERCE**

**BUREAU OF THE CENSUS**

**WASHINGTON** 1816

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

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Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: James Thomas Batts

Who died at _____ on Jan 25 - 1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race B ~~Single,~~ ~~married~~, widowed or ~~divorced~~: _____

Date of birth _____ Age: Years 66 Months 10 Days 11

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

(b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) Not Epidemic encephalitis

Birthplace of father (State or country) Toxic condition from food

Birthplace of mother (State or country) follow a week of as taking infected food

Principal cause of death: Encephalitis Lethargic following food poisoning - rotten frozen apples

Other contributory causes of importance Eating decayed food

Name of operation none Date of _____

What test confirmed diagnosis? clinical Was there an autopsy? no

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19__

Where did injury occur? _____
(Specify city or town, county and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician E A Weir

Address of physician Meadville Mo

Signature of Registrar E A Weir

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh MD

Special Agent.

Reg. Dist. No. 503

Primary Reg. Dist. No. 4306

T.C

5-1816