

N. R.—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.

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

Do not use this space.

OCT 3 0 1935

1. PLACE OF DEATH

County *Schuyler*
Township *Fabius*
City *Downing* (No.)

Registration District No. *802*
Primary Registration District No. *6046*

File No. *31543*

Registered No.
St. Ward)

2. FULL NAME

Linda Alice Botts

(a) Residence. No. St. Ward.
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

white

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

married

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

Alberts Botts

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

5-11-1876

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

59

3

23

8. OCCUPATION OF DECEASED

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

housewife

(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)

Davis Co. Iowa

10. NAME OF FATHER

Herman Henry Altheide

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Germany

12. MAIDEN NAME OF MOTHER

Rubana Adeline Neis

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Ill.

14.

INFORMANT
(Address)

*my Albert Botts
Downing Mo*

15.

FILED *9-6* 1935

J R B wafes

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

Sep 4 1935

17. I HEREBY CERTIFY, That I attended deceased from

not 1934 *Sep 4* 1935
that I last saw him alive on *Sep 4* 1935 and that death occurred, on the date stated above, at *8 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

*Cancer of Stomach and
the whole abdominal
vicera*

CONTRIBUTORY
(SECONDARY)

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) *H. E. Gerwig*, M. D.

, 19 (Address) *Downing 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

DATE OF BURIAL

Downing Cemetery

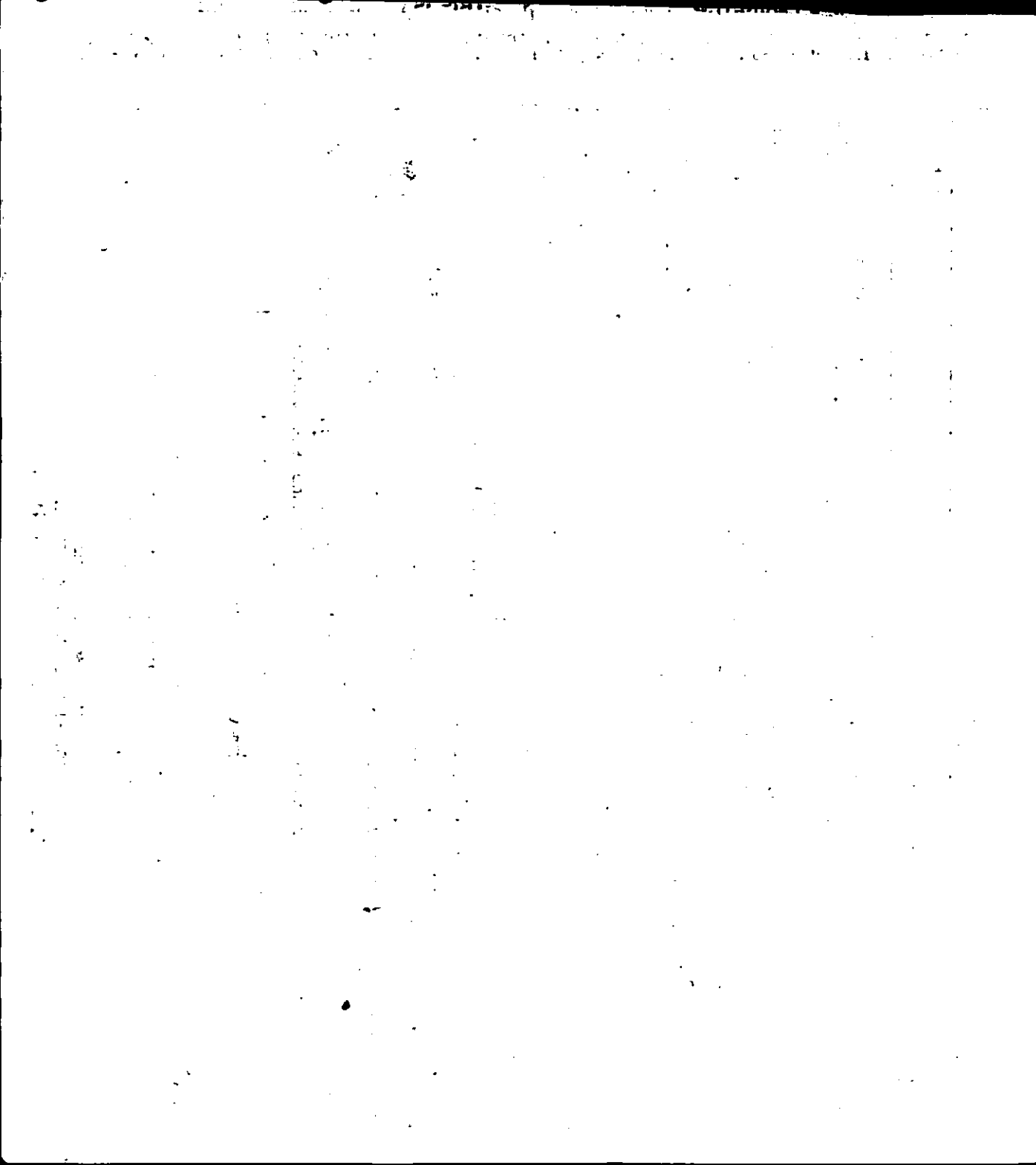
Sept 6 1935

20. UNDERTAKER

ADDRESS

*John A. Roberts
By True Marched*

Downing Mo



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLY

1. PLACE OF DEATH

County Schuyler
Township Jubilee
City (No. St. Ward)

Registration District No. 802
Primary Registration District No. 6046

File No.
Registered No.

2. FULL NAME

(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 <u>7</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE <u>39</u>	YEARS <u>3</u>	MONTHS <u>3</u>
DATE <u> </u>		If LESS than 1 day, hrs. or min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
	9. Industry or business in which work was done, as mill, mill, saw mill, bank, etc.
	10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation	

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 1925 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 4 1935

22. I HEREBY CERTIFY, That I attended deceased from , 1935, to , 1935.
I last saw him alive on , 1935. Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

Cancer of uterus and the whole abdominal viscera
as noted
Dr. T. T. T.

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury , 1935

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

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) H. E. Gerwig, M. D.
(Address)

5-31543