

REG'D SEP 23 1938

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

29176

Do not use this space.

1. PLACE OF DEATH

(a) County Jasper Registration District No. 411  
 (b) Township John Primary Registration District No. 2002 Registered No. \_\_\_\_\_  
 (c) City John (d) Street No. St. John Hospital John, Mo.  
 (If death occurred in hospital or institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 445 E. 11th St. St. Baxter Springs, Kas.  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 24, 1938

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

22. I HEREBY CERTIFY, That I attended deceased from 8/19, 1938, to 8/24, 1938

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 4, 1918

I last saw him alive on 8/24, 1938. Death is said to have occurred on the date stated above, at 12 a. m.

7. AGE YEARS MONTHS DYS If LESS than 1 day, hrs. or min. 20 1 20

The principal cause of death and related causes of importance were as follows:

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 9. Industry or business in which work was done, as saw mill, bank, etc. None  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

otitis media  
mastoiditis  
Reatitis  
Date of onset July 9, 1938  
1925

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Baxter Springs, Kansas

Other contributory causes of importance: 59

FATHER 13. NAME M. A. E. Bottom

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cherokee Co., Kansas

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

MOTHER 15. MAIDEN NAME Ruth Carter

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

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Cherokee Co., Kansas

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

17. INFORMANT (ADDRESS) Mr. A. E. Bottom, Baxter Springs, Kas.

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

18. BURIAL, CREMATION, OR REMOVAL PLACE Columbus, Mo. DATE Aug 25, 38

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

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Boice and Co., Galena, Kansas.

Manner of injury \_\_\_\_\_

20. FILED 8-26-38 Ed. J. James Local Registrar.

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify H. E. Spence M. D.  
(Signed) Baxter Springs, Kansas  
(Address)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 6,

District File Number 6-38-193

Date Filed 9/20/38

**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 .....

Registered Apprentice No. ...., working under my personal supervision.

Signed .....

Licensed Embalmer No. ....

P. O. Address .....

**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 this body is not embalmed, above space should be left blank.**