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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 1 1948

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25345

Registration District No. _____ Primary Registration District No. 5000 Registrar's No. 247

1. PLACE OF DEATH:

(a) County ADAIR

(b) City or town RURAL — BENTON
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ✓ /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 3 DAYS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State IOWA (b) County POLK 999

(c) City or town DES MOINES 13
(If outside city or town limits, write "RURAL")

(d) Street No. 4460 S.E. 16th ST 0
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 2

If yes, name country _____

3. (a) PRINT FULL NAME WILLIAM HENRY KOTTKAMP

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex MALE 0 | 5. Color or race WHITE | 6. (a) Single, widowed, married, divorced MARRIED 1

6. (b) Name of husband or wife JULIA KOTTKAMP 6. (c) Age of ~~husband or~~ wife if alive 42 years

7. Birth date of deceased FEBRUARY (Month) 17 (Day) 1906 (Year)

8. AGE: Years 42 | Months 5 | Days 17 | If less than one day _____ hr. _____ min.

9. Birthplace CHAMPAIGN (City, town, or county) ILLINOIS 1 (State or foreign country)

10. Usual occupation LABORER

11. Industry or business _____

FATHER
12. Name HENRY KOTTKAMP
13. Birthplace UNKNOWN (City, town, or county) UNKNOWN 1 (State or foreign country)

MOTHER
14. Maiden name EVA STEEL
15. Birthplace CHAMPAIGN (City, town, or county) ILLINOIS 1 (State or foreign country)

16. (a) Informant Mrs. Wm Kottkamp
(b) Address 4460 S.E. 16th ST. DESMOINES IOWA

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-7-1948 (Month) (Day) (Year)
(c) Place: burial or cremation GREEN GROVE CEMETERY

18. (a) Signature of funeral director Hunt Funeral Home
(b) Address Kirksville, Mo

19. (a) 8-25-48 (Date received local registrar) (b) Kate Lambert (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 5
year 1948 hour 11 minute 30 A M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__;
that I last saw h_____ alive on _____, 19__;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death SUICIDE, WHILE DESPONDENT	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy CAUSTIC POISON	

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PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) SUICIDE

(b) Date of occurrence AUG. 5, 1948

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury 3

23. Signature Foster R. Easley, CORONER (M.D. or other)
Address BRASHEAR MO Date signed 8/14-48

(Licensed Embalmer's Statement on Reverse Side)

USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEB 14 1949

RECEIVED
District Health Officer No. 10
District File Number 8-48-163
Date Filed AUG 31 1948

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, [redacted].....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Clarence M. Bilo

Licensed Embalmer No. 4375

P. O. Address Kirksville, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.