

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 13765

BIRTH NO. _____ REG. DIST. NO. 209 PRIMARY REG. DIST. NO. 3043 Registrar's No. 138

0630

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Marion	
b. CITY (If outside corporate limits, write RURAL and give township) Hannibal		c. CITY (If outside corporate limits, write RURAL and give township) Hannibal 0630	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Elizabeth Hosp.		d. STREET ADDRESS (If rural, give location) 3710 West Ely R d. 0	

3. NAME OF DECEASED (Type or Print) a. (First) Thea b. (Middle) c. (Last) Botter			4. DATE OF DEATH (Month) (Day) (Year) 4 30 1950		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH March 23, 1919			9. AGE (In years last birthday) 31 IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HARDWELL KY.
12. CITIZEN OF WHAT COUNTRY?			13a. FATHER'S NAME C.B. Crider		
13b. MOTHER'S MAIDEN NAME Hettie Holt			14. NAME OF HUSBAND OR WIFE William D. Botter		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William D. Botter Hannibal, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc.—It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Metastatic Carcinoma Primary site undetermined ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 6 mo. 1998	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Dec 1949** to **April 30, 1950**, that I last saw the deceased alive on **April 30, 1950**, and that death occurred at **12:25 m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) M. L. Belli M.D.		23b. ADDRESS Hannibal Mo.		23c. DATE SIGNED April 30/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 5/1/50		24c. NAME OF CEMETERY OR CREMATORY Melburn Kentucky	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Dr. E. M. Lucke		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hannibal Mo.	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED MAY 3 1950
MARION CO. HEALTH DEPT.
DATE FILED MAY 4 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed H. Crawford Smith

Licensed Embalmer No. 3814

P. O. Address Henniker, Me.

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, fact should be so stated above.