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FILED SEP 16 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

30798
STATE FILE NUMBER

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 332

1. PLACE OF DEATH
a. COUNTY: BOONE
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): COLUMBIA — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): ELLIS FISCHEL — Length of stay in 1b: 46 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI b. COUNTY: CRAWFORD
c. CITY OR TOWN: STEELVILLE D28 — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): R.F.D. # 2 — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: GEORGE Middle: Michael Last: BETTORF

4. DATE OF DEATH Month: 9 Day: 10 Year: 1957

5. SEX: Male **6. COLOR OR RACE:** White **7. MARRIED** [ ] **NEVER MARRIED** [X] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: 1-31-1872

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Cleveland, OHIO
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13a. FATHER'S NAME: CHRIS BETTORF
13b. MOTHER'S MAIDEN NAME: MARY ASHMAN
14. NAME OF HUSBAND OR WIFE: NONE

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.: —
17. INFORMANT Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia, hypostatic	10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Fracture of left hip	6 wks
DUE TO (c)	/	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Benign prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21: I attended the deceased from 7-26-57, to 9-10-57 and last saw ~~him~~ him alive on 9-10-57
Death occurred at 11:10 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Richard E. Johnson, MD
22b. ADDRESS: Columbia, Mo
22c. DATE SIGNED: 9-10-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 9-10-57
23c. NAME OF CEMETERY OR CREMATORY: Hiller Cemetery
23d. LOCATION (City, town, or county): Steelville (State): Mo

24. FUNERAL DIRECTOR: L. P. Franklin
ADDRESS: Cuba, Mo.
25. DATE RECD. BY LOCAL REG.: Sept 10 1957
26. REGISTRAR'S SIGNATURE: Mrs. R. E. Palmer

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 7473

P. O. Address Cuba, Mo.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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