

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

47210

STATE FILE NUMBER

FILED JAN 17 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6081

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>KANSAS CITY</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>KRESTWOOD MEDICAL Hosp.</u>		Length of stay in lb <u>6 1/2 YRS</u>	d. STREET ADDRESS (If outside, give location) <u>7203 Bellefontaine</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>Melville</u> Last <u>BOTTORFF</u>			4. DATE OF DEATH Month <u>DEC.</u> Day <u>21</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 16, 1871</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	11. BIRTHPLACE (City and state or country) <u>CLARK COUNTY INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>SAMUEL BOTTORFF</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA BOTTORFF</u>		14. NAME OF HUSBAND OR WIFE <u>LOTTIE MAY BOTTORFF</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT Address <u>MISS NELLIE BOTTORFF 7203 BELLEFON. KC MO</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cocaine & fungus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>arteriosclerotic heart disease</u>	DUE TO (c) _____			<u>6-8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>			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.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		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 <u>1936</u> to <u>12-21-57</u> and last saw her alive on <u>12-21-57</u> Death occurred at <u>9:30 P.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Name or title) <u>D. W. Newcomers Sons</u>			22b. ADDRESS <u>6627 Pleasant View</u>		22c. DATE SIGNED <u>12-22-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>12-23-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MEADVILLE CEMETERY</u>	23d. LOCATION (City, town, or county) <u>MEADVILLE</u>	(State) <u>MISSOURI</u>	
24. FUNERAL DIRECTOR <u>D. W. Newcomers Sons</u>		ADDRESS <u>351 BRUSH CREEK KANSAS CITY MO.</u>	25. DATE RECD. BY LOCAL REG. <u>12-23-57</u>	26. REGISTRAR'S SIGNATURE <u>Neva Marshall</u>	

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Geo. C. Kealhofer

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 *Vern Lawler*

Licensed Embalmer No. *4915*
P. O. Address *778 32nd St KC*

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.