

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-004956

STATE FILE NUMBER

FILED FEB 26 1958

Registration District No. 99

Primary Registration District No. 5373

Registrar's No. 25

300

1-57

1. PLACE OF DEATH a. COUNTY <b>DeKalb</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>DeKalb</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Maysville (West Camden)</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Maysville</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Home</b>		Length of stay in 1b <b>63 Yrs</b>	d. STREET ADDRESS (If outside, give location) <b>2328</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>RICHARD</b> Last <b>MOTT</b>			4. DATE OF DEATH Month <b>Feb.</b> Day <b>16</b> Year <b>1958</b>	
--	--	--	--	--

5. SEX <input checked="" type="checkbox"/> Male	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25 1894</b>	9. AGE (In years last birthday) <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
---	-------------------------------	---	---	---	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Maysville Mo. (Rural)</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
--	-----------------------------------	--	---

13a. FATHER'S NAME <b>Andrew Mott</b>	13b. MOTHER'S MAIDEN NAME <b>Caroline Lehman</b>	14. NAME OF HUSBAND OR WIFE <b>Neither</b>
--	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Miss Jennie Mott, Maysville Missouri</b> Address
---	-------------------------	---

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>Cerebral Embolism</u> DUE TO (b) <u>Cerebral Obliteration</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 50 min.</u> <u>?</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 type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>4201</b>
---	---

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>4201</b>	COUNTY	STATE
---	--	--	---	--------	-------

21. I attended the deceased from <u>June 1944</u> to <u>2/16/58</u> and last saw him alive on <u>2/15/58</u> Death occurred at <u>12:35 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>W. S. Stoddard, M.D.</u>	22b. ADDRESS <b>Maysville Missouri</b>	22c. DATE SIGNED <b>2-18-58</b>
--	--	---	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-19-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>	23d. LOCATION (City, town, or county) <b>Maysville Missouri</b>	(State)
--	-----------------------------	---	--	---------

24. FUNERAL DIRECTOR <b>Pilcher Funeral Home, Maysville Mo.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>2-18-58</b>	26. REGISTRAR'S SIGNATURE <u>W. S. Stoddard</u>
--	---------	--	--

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

2

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  .....  
C. F. Pilcher

Licensed Embalmer No. .... 3960 .....  
P. O. Address Mayeville 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.