

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-002753  
STATE FILE NUMBER  
2 852

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

FILED FEB 16 1959

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Ferguson 4119
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hosp.		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 409 South Dade Ave.
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CLARA LILY BOTTUM			4. DATE OF DEATH Month Day Year January 23, 1959		
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5. SEX Female 1	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1880	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days 2 12	IF UNDER 24 HRS. Hours Min. 
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Carrollton, Illinois 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Gottgetreu	13b. MOTHER'S MAIDEN NAME Clara Arondt	14. NAME OF HUSBAND OR WIFE Walter H. Bottum
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Oscar J. Heil, 409 South Dade Ave.
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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>myocardial infarction, acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>
Conditions, if any, which gave rise to above cause (a), stating the under- lying cause last.	DUE TO (b) <u>coronary artery thrombosis</u>	<u>15 minutes</u>
	DUE TO (c) <u>arteriosclerosis 420.1</u>	<u>4 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). <u>Chronic cholelithiasis; Hybertensive contributesspm</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.
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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
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21. I attended the deceased from Death occurred at <u>Jan 3 1959</u> to <u>Jan. 23, 1959</u> and last saw <u>her</u> alive on <u>Jan. 23, 1959</u> <u>8:30 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>Joseph Edwards</u> (Degree or title) M.D.	22b. ADDRESS 3720 Washington	22c. DATE SIGNED 1/24/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 26, 1959	23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	23d. LOCATION (City, town, or county) St. Louis County, Missouri
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24. FUNERAL DIRECTOR Ambruster Mortuary, 6633 Clayton Rd.	ADDRESS 6633 Clayton Rd.	25. DATE RECD. BY LOCAL REG. JAN 26 '59	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> m.d.o.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

P- 12/20

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 *Fred J. Turner* .....

Licensed Embalmer No. *11788* .....

P. O. Address *11788* .....

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.