

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022043

STATE FILE NUMBER

FILED JUL 7 1959

Registration District No. 171 Primary Registration District No. 5639 Registrar's No. 30

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY <i>Lafayette Lafayette</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo. Mo.</i> b. COUNTY <i>Lafayette</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Mayview</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <i>Mayview</i> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT Hospital, give location) HOSPITAL OR INSTITUTION <i>5 mi. south Mayview</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>5 mi south Mayview</i>	
3. NAME OF DECEASED (Type or print) First <i>Doris</i> Middle <i>Marie</i> Last <i>Pitts</i>		4. DATE OF DEATH <i>June 27 1959</i>	
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/5/1919</i> (In years last highday) 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) <i>Sales Sales</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cosmetic products Union Star Mo.</i>	
11. BIRTHPLACE (City and state or country) <i>Union Star Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>Edgar C. Bottorff</i>		13b. MOTHER'S MAIDEN NAME <i>Elsie Cornelius</i>	
14. NAME OF DECEASED'S MOTHER <i>Andrew J. Pitts</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No.</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Andrew J. Pitts Mayview Mo.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca of cervix</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) _____		171X	
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.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ 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 COUNTY STATE	
21. I attended the deceased from <i>Apr. 16, 1959</i> to <i>June 27, 1959</i> and last saw her alive on <i>June 24, 1959</i> Death occurred at <i>1:45 pm</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>H. E. Fulcheron M.D.</i>		22b. ADDRESS <i>Higginsville Mo</i>	
22c. DATE SIGNED <i>6-27-59</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
23b. DATE <i>6/29/59</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Tabor Cemetery</i>	
23d. LOCATION (City, town, or crossroad) (State) <i>Adessa, Mo.</i>		24. FUNERAL DIRECTOR ADDRESS <i>Husman-Sparks Adessa, Mo.</i>	
25. DATE RECD. BY LOCAL REG. <i>6/29/59</i>		26. REGISTRAR'S SIGNATURE <i>Emma Davidson</i>	

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

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 *William T. Sparks*

Licensed Embalmer No. *4431*  
P. O. Address *Odessa, Fla.*

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.