

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031361

FILED VS OCT 2 1959

STATE FILE NUMBER

Registration District No. 002 Primary Registration District No. 5069 Registrar's No. 87

1. PLACE OF DEATH a. COUNTY <u>ANDREW</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Nodaway</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ROCHESTER TOWNSHIP</u>		Length of stay in 1b <u>4 years</u>	c. CITY OR TOWN <u>Barnard</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>SHADY LAWN</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES BYRON STOTTS</u>			4. DATE OF DEATH Month Day Year <u>September 18, 1959</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>12/12/78</u>	9. AGE (last birthday) <u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Nodaway County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>James Harvey Stotts</u>		13b. MOTHER'S MAIDEN NAME <u>unk.</u>		14. NAME OF HUSBAND OR WIFE <u>Ellen Stotts</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>488-14-3521</u>	17. INFORMANT Address <u>William Stotts, Bolckow, 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>Gastro-intestinal hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Probably Strangulated Hernia</u>					unknown	
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)				
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year						
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 <u>1-23-57</u> to <u>9-18-59</u> and last saw him <input checked="" type="checkbox"/> her alive on <u>9-17-59</u> Death occurred at <u>3:30 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Sign and print name) <u>Lillian B. Kelley</u>			22b. ADDRESS <u>Savannah, Missouri</u>		22c. DATE SIGNED <u>9-18-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>9/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Barnard Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Barnard Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Breit Funeral Home, Savannah</u>		25. DATE RECD. BY LOCAL REG. <u>9-22-59</u>	26. REGISTRAR'S SIGNATURE <u>Lillian Sparks</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James B. Hawkins

Licensed Embalmer No. 4536

P. O. Address Savannah

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.