

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 22 1960

60-010406

Registration District No. 99 Primary Registration District No. 41188 Registrar's No. 12

STATE FILE NUMBER

|   |   |   |  |  |   |   |  |  |      |
|---|---|---|--|--|---|---|--|--|------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>DeKalb</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>DeKalb</b> |   |   |  |  |      |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Maysville</b>   |   | Length of stay in 1b<br><b>25Yrs.</b>   |  | c. CITY OR TOWN <b>Maysville</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |  |  |      |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  | d. STREET ADDRESS (If outside, give location)                           |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |      |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARGARET</b> Middle <b>J.</b> Last <b>BOTTORFF</b>  |   |   |  | 4. DATE OF DEATH<br>Month <b>Feb.</b> Day <b>26</b> Year <b>1960</b>   |   |   |  |  |      |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>                  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/21-87</b>  | 9. AGE (last birthday)<br><b>72</b>                                     | IF UNDER 1 YEAR<br>Months   | IF UNDER 24 HR<br>Days                     | Hours  | Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (City and state or country)<br><b>Andrew County, Mo.</b> |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b> |  |      |
| 13a. FATHER'S NAME<br><b>David Kephart</b>  |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Elizabeth Anderson</b>                               |  |   | 14. NAME OF HUSBAND OR WIFE<br><b>Lewis Bottorff</b>  |  |  |      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address<br><b>Lewis Bottorff, Maysville Mo</b>            |   |  |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure (Heart Block)</b>  |   |   |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                          |      |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Influenza</b>   |   |   |  |  |   |   |  | <b>4 weeks</b>   |      |
| DUE TO (c) <b>Cardio-nephritis (Hypertension)</b>   |   |   |  |  |   |   |  | <b>12 years</b>  |      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>None</b>  |   |   |  |  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |  |  |      |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20a. ACCIDENT <input checked="" type="checkbox"/> | SUICIDE <input checked="" type="checkbox"/>   | HOMICIDE <input checked="" type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |   |  |  |      |
| 20c. TIME OF INJURY<br>Hour<br>a.m.<br>p.m.   |   | Month, Day, Year  |  |  |   |   |  |  |      |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/><br>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 <b>April 1948</b> to <b>death 2/26/60</b> last saw her <b>alive</b> on <b>Feb. 25, 1960</b><br>Death occurred at <b>9</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |  |   |   |  |  |      |
| 22a. SIGNATURE (Degree or title)<br><b>Blair Johnson, M.D.</b>  |   |   |  | 22b. ADDRESS<br><b>Maysville Missouri</b>  |   |   |  | 22c. DATE SIGNED<br><b>2/29-60</b>   |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 23b. DATE<br><b>2/29-60</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn</b>                                |  | 23d. LOCATION (City, town, or county)<br><b>Maysville Mo.</b>           |   |  |  |      |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Pilcher Funeral Home Maysville Mo.</b>   |   |   |  | 25. DATE RECD. BY LOCAL REG.<br><b>3-17-1960</b>   |   | 26. REGISTRAR'S SIGNATURE<br><b>Russell Davidson</b>  |  |  |      |

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  \_\_\_\_\_  
C. T. Pilcher

Licensed Embalmer No. 3960

P. O. Address Maysville 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.