

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS JUL 19 1960

-60-025745

Registration District No. 15 Primary Registration District No. 3004 Registrar's No. 75 STATE FILE NUMBER

| | | | |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Barton</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Jasper</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Lamar</u> | Length of stay in 1b <u>2 mos.</u> | c. CITY OR TOWN <u>Carthage</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>Gilbert Rest Home</u> | | d. STREET ADDRESS (If outside, give location) <u>316 Fulton St.</u> | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>Charlie</u> Middle <u>Bottner</u> Last <u></u> | 4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1960</u> |
|--|--|

| | | | | | | |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|---|--|
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/4/1872</u> | 9. AGE (last birthday) <u>88</u> | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
|-----------------------|----------------------------------|---|-------------------------------------|-------------------------------------|---|--|

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

| | | |
|--------------------|---------------------------|-----------------------------|
| 13a. FATHER'S NAME | 13b. MOTHER'S MAIDEN NAME | 14. NAME OF HUSBAND OR WIFE |
|--------------------|---------------------------|-----------------------------|

| | | | |
|--|-------------------------|---------------------------------|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT <u>Records</u> | 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>Cardiac Failure</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>—</u> | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Arteriosclerotic changes of feet</u> | | <u>—</u> |
| | DUE TO (c) <u>Generalized Arteriosclerosis</u> | | <u>—</u> |

| | |
|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bacteria</u> | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N- <input type="checkbox"/> Unknown |
|--|--|

| | | |
|---|---|--|
| 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.) |
|---|---|--|

| | | | | | |
|---|--|--|------------------------------|--------|-------|
| 20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u> Month, Day, Year <u>—</u> | 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 5-10-60 to 7-12-60 and last saw him alive on 7-12-60.
 Death occurred at 5:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Thomas Barall - MD</u> | 22b. ADDRESS <u>1209 1/2 St - Lower Miami</u> | 22c. DATE SIGNED <u>7-14-60</u> |
|---|--|------------------------------------|

| | | | |
|--|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>7/15/1960</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Webb City Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Webb City, Mo.</u> |
|--|-------------------------------|---|--|

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR <u>Hedge-Lewis Funeral Home, Webb City, Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>JUL 14 '60</u> | 26. REGISTRAR'S SIGNATURE <u>Marie Konantz</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 J. Lewis

Licensed Embalmer No. 156

P. O. Address Wells

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.