

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-043740

STATE FILE NUMBER

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 454

FILED DEC 26 1961

1. PLACE OF DEATH a. COUNTY BUTLER			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ARKANSAS COUNTY LAWRENCE			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN POPLAR BLUFF		Length of stay in 1b 109 DAYS	c. CITY OR TOWN ALICIA		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) NONE		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLOYD Middle SHELTON Last BOTTORFF			4. DATE OF DEATH Month DECEMBER Day 2 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> (Sep) Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-13-92	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE	11. BIRTHPLACE (City and state or country) STRANGERS HOME, ARK.	12. CITIZEN OF WHAT COUNTRY USA		
13a. FATHER'S NAME JAMES T. BOTTORFF		13b. MOTHER'S MAIDEN NAME RUTH CHILDERS		14. NAME OF HUSBAND OR WIFE CARRIE LEE BOTTORFF		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VA HOSPITAL RECORDS, POPLAR BLUFF, MO.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GIANT CELL SARCOMA OF FOOT WITH PULMONARY METASTASES.					INTERVAL BETWEEN ONSET AND DEATH 21 MONTHS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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 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 _____ 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 VA August 15, 1961 to December 2, 1961 and last saw him alive on _____ Death occurred at 5:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>Robert S. Cohen</i> ROBERT S. COHEN, M.D., Chief, Medical Service		(Degree or title)	22b. ADDRESS VA Hospital, Poplar Bluff, Mo		22c. DATE SIGNED 12-5-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12-4-61	23c. NAME OF CEMETERY OR CREMATORY Strangers Home Cem.	23d. LOCATION (City, town, or county) Rt 1 Alicia, Arkansas	(State)		
24. FUNERAL DIRECTOR Higginbotham's Walnut Ridge, Ark		ADDRESS	25. DATE RECD. BY LOCAL REG. 12/20/1961	26. REGISTRAR'S SIGNATURE <i>Thelma Graham</i>		

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DEC 27 1961

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.