

DES'D SEP 15 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

28901  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Clay Registration District No. 197  
 (b) Township Gallatin Primary Registration District No. 5276A  
 (c) City North K. C. R.F.D. (Maple Park) Home (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (d) Street No. Home  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth yrs. mos. ds.  
 320

2. PRINT FULL NAME Samuel Alonzo Botts  
 (a) Residence, No. North Kansas City, Mo., R. F. D. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write the word*) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF unknown

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 22, 1871

7. AGE YEARS 67 MONTHS 11 DAYS 21 If LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as janitor  
 9. Industry or business in which work was done, as janitor  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) Bloomington, Ill  
 (STATE OR COUNTRY)

FATHER  
 13. NAME Samuel A. Botts  
 14. BIRTHPLACE (CITY OR TOWN) unknown  
 (STATE OR COUNTRY)

MOTHER  
 15. MAIDEN NAME Hedgger  
 16. BIRTHPLACE (CITY OR TOWN) unknown  
 (STATE OR COUNTRY)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 13, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 8, 1939, to Aug 8, 1939  
 I last saw him alive on Aug 6, 1939 Death is said to have occurred on the date stated above, at 5 P. M.  
 The principal cause of death and related causes of importance were as follows:

Cardiac Failure  
Senile Dementia

Other contributory causes of importance:

Name of operation..... Date of.....  
 What test confirmed diagnosis? clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?.....  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....  
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify.....  
 (Signed) W. H. State, M. D.

(Address) N. Kansas City, Mo.

17. INFORMANT Louise Smith  
 (ADDRESS) North K. C. R. F. D. (Maple Park)

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Clay County Farm DATE Aug 15, 1939

19. FUNERAL DIRECTOR (NAME) Morton Funeral Home  
 (ADDRESS) 832 Armour Road, North K. C. Mo.

20. FILED Aug 30, 1939 Viola C. Meyer  
 Local Registrar.

Per L.M.A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1622

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 9/21/39

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 \_\_\_\_\_

Registered Apprentice No. \_\_\_\_\_, working under my personal supervision.

Signed *Harold L. Pearson*

Licensed Embalmer No. 3605

P.O. Address *Walden, N.C.*

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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

28901  
Do not use this space.

1. PLACE OF DEATH

(a) County Clay Registration District No. 199  
(b) Township Ballastan Primary Registration District No. 3276 Registered No. ....  
(c) City ..... (d) Street No. ....  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Samuel Alonzo Betts  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
67 11 21

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 13 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... to .....

I last saw h. .... alive on ..... 19..... Death is said to have occurred on the date stated above, at ..... m.

The principal cause of death and related causes of importance were as follows:

Cardiac failure  
senile dementia  
93C

Other contributory causes of importance:

Chronic Myocarditis

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? ..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....

If so, specify

(Signed) A. D. Pate , M. D.

(Address) N. Kansas City

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

S-28901