

FILLED SEP 26 1941

State File No. _____

Registration District No. 104

Primary Registration District No. 3008 ✓

Registrar's No. 211

1. PLACE OF DEATH: Callaway
 (a) County Callaway
 (b) City or town Fulton Mo.
 (c) Name of hospital or institution State Hospital #1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution since 5-8-1941
 (Specify whether
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Macon Co.
 (c) City or town Bavaria 14
 (If outside city or town limits, write "RURAL")
 (d) Street No. R.F.D. #2
 (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Sarah Emma Botts

MEDICAL CERTIFICATION

3. (b) If veteran, name war _____ 3. (c) Social Security No. D.K.

20. DATE OF DEATH: Month Aug. day 2nd year 1941 hour 12 minute 40 P.M.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 9

21. I hereby certify that I attended the deceased from July twentieth, 1941, to August 2nd, 1941, that I last saw her alive on August 1st, 1941, and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife LOUIS P. BOTT 6. (c) Age of husband or wife if alive D.K. years

Immediate cause of death Terminal broncho-pneumonia 3 days
acute gastro-enteritis 11 days

7. Birth date of deceased D.K.
 (Month) (Day) (Year)

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hr. _____ min.

Due to _____
 Due to _____

9. Birthplace D.K. D.K.
 (City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____

10. Usual occupation Housewife

Major findings: Of operations _____

11. Industry or business _____

Of autopsy _____

12. Name Chas. C. Burge

13. Birthplace Ohio Ohio
 (City, town, or county) (State or foreign country)

14. Maiden name Sally Crabtree

15. Birthplace Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Hosp. records

(b) Address Fulton

17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Reveries, Macon Co.

18. (a) Signature of funeral director H. J. Edwards

(b) Address Reveries, Mo

19. (a) 8-2-41 (b) R. N. Crews
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address State Hosp. Fulton Date signed 8/2/41

MOTHER FATHER

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

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.....

H. L. Edwards

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Revere, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
3-21-41
X29288

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31197

Registration District No. 104

Primary Registration District No. 3008

Registrar's No.

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Truitt
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp no 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. _____ (Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Sarah E. Bott
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____
4. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased 2. 5
(Month) (Day) (Year)

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____
(City, town, or county) (State or foreign country)

{ 14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

~~17. (a) Removal~~ (b) Date thereof Aug 2, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) Aug 2, 1941 (b) R. N. Crewe
(Date received local registrar) (Registrar's signature)

Nov. 3, 1941.

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 2 Year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

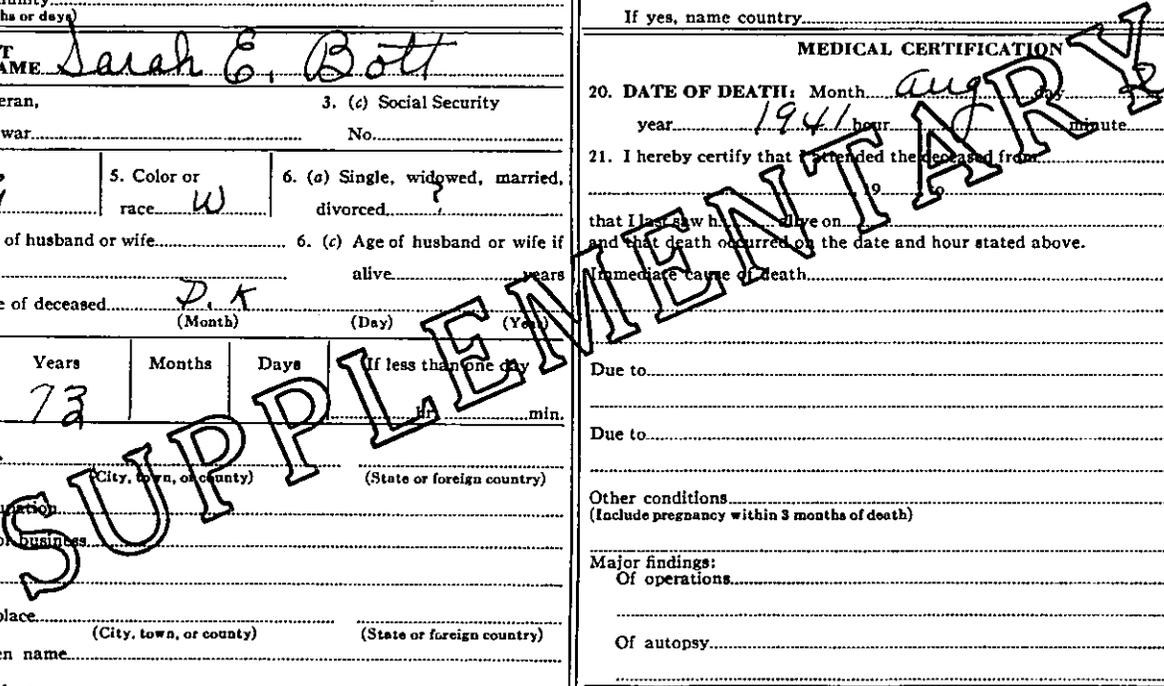
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____
(Specify type of place)
While at work? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____
Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD



1941
S-31197