. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED APR 14 1948

Registration District No. 397

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 11017

Registrar's No. 876

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Jefferson Barracks, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 169 (Specify whether years, months or days)
In this community: 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: [redacted]
(c) City or town: St. Louis (If outside city or town limits, write "RURAL")
(d) Street No.: 3002 No. Prairie (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country: --

3. (a) PRINT FULL NAME: BOTTORFF, John Robert
3. (b) If veteran, name war: II
3. (c) Social Security No.: 490 22 7719
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife: -
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: July 23, 1925 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
22	8	10	hr. min.

9. Birthplace: St. Louis, Missouri (City, town, or county) (State or foreign country)
10. Usual occupation: Electrician
11. Industry or business: --
12. Name (Father): Robert Bottorff
13. Birthplace (Father): Salem, Missouri (City, town, or county) (State or foreign country)
14. Maiden name (Mother): Jesse Walker
15. Birthplace (Mother): Portor, Oklahoma (City, town, or county) (State or foreign country)
16. (a) Informant: Registrar -VAH,
(b) Address: Jefferson Barracks, Mo.
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation: National Cemetery
18. (a) Signature of funeral director: A. Kron L & U Co.
(b) Address: 2707 N. Grand, St. Louis, Mo.
19. (a) 4-6-48 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: April day: 3 year: 1948 hour: 3 minute: 40 a.m.
21. I hereby certify that I attended the deceased from October 16, 1947, to April 3, 1948, that I last saw him alive on April 3, 1948, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
METASTATIC SEMINOMA	Unk
OF THE TESTIS; INVOLVING LUNGS,	
HEART, LIVER, MESENTERIC NODES,	
LEFT KIDNEY, ILIAC VESSELS, &	
LEFT SUPRACLAVICULAR NODES	
Due to: THROMBOSIS OF ILEUS AND RIGHT	
RENAL VEINS	Unk
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations: 5/5/47 -Rt. Orchidectomy
Of autopsy: Autopsy performed (see cause of death)

PHYSICIAN — Underline the cause of which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): no
(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? Means of injury:
23. Signature: L. E. Stilwell, (M. D. or coroner) L. E. Stilwell
Address: VAH, Jeff. Brks., Mo. Date signed: 4/5/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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, fact should be so stated above.