

FILED NOV 21 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATHR.W. Matheny
State File No. 37872BIRTH NO. 75128-50 REG. DIST. NO. 167 PRIMARY REG. DIST. NO. 3040 Registrar's No. 176

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe Mo</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe Mo</u>	
c. LENGTH OF STAY (In this place) <u>48 hrs</u>		d. STREET ADDRESS (If rural, give location) <u>Chillicothe Mo</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Chillicothe Hosp Chillicothe</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Peggy</u> b. (Middle) <u>Ann</u> c. (Last) <u>Bothwell</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-10-50</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>11-7-50</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W</u>	11. BIRTHPLACE (State or foreign country) <u>Chillicothe, Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U</u>	

13a. FATHER'S NAME <u>Wells M^c Coy Bothwell</u>	13b. MOTHER'S MAIDEN NAME <u>Jewell Marie Reagan</u>	14. NAME OF HUSBAND OR WIFE <u>Ted Hall - Breckenridge Mo</u>
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. <u>W</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Ted Hall - Breckenridge Mo</u>

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>6 mos.</u> <u>77.30</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>RESPIRATORY FAILURE</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>PRE NATAL TOXEMIA</u> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-8, 1950, to 11-10, 1950, that I last saw the deceased alive on 11-9, 1950, and that death occurred at 6:41 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R.W. Matheny M.D.</u>	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>11-10-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-11-50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>	24d. LOCATION (City, town, or county) (State) <u>Breckenridge Mo</u>
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DATE REC'D BY LOCAL REG. <u>11-10-50</u>	REGISTRAR'S SIGNATURE <u>Frances B Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edmond Babin</u>	ADDRESS <u>Babin</u>
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

J. J. J. J. J.

Signed.....
Student Embalmer

Licensed Embalmer No. *4495*

P. O. Address *Box 98, Dickinson, N.D.*

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.