

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043117

STATE FILE NUMBER

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 210

DO NOT WRITE ON THIS STUB

AMENDED

<p>FILED NOV 26 1962</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Jasper</u></p> <p>b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Carthage</u> Length of stay in lb <u>40 min.</u></p> <p>c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McCune-Brooks hospital</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/></p>		<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Missouri</u> COUNTY <u>Newton</u></p> <p>c. CITY OR TOWN <u>Diamond</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p> <p>d. STREET ADDRESS (If outside, give location) <u>Route 1</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/></p>						
<p>3. NAME OF DECEASED First Middle Last <u>CRAIG DAVID BLOTTER</u></p> <p>4. DATE OF DEATH Month Day Year <u>NOVEMBER 11, 1962</u></p>			<p>5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH <u>11-11-62</u> 9. AGE (last birthday) <u>0</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HR Hours <u>0</u> Min <u>40</u></p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (City and state or country) <u>Carthage, Mo</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>USA</u></p>		
<p>13a. FATHER'S NAME <u>Alfred Blotter</u></p>			<p>13b. MOTHER'S MAIDEN NAME <u>Donna Snider</u></p>			<p>14. NAME OF HUSBAND OR WIFE <u>none</u></p>		
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u></p>				<p>16. SOCIAL SECURITY NO. <u>none</u></p>		<p>17. INFORMANT Address <u>Alfred Blotter, Rte 1, Diamond, Mo</u></p>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:</p> <p style="text-align: center;">IMMEDIATE CAUSE (a) <u>Aspirin</u></p> <p>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Congenital Deficiency of Thorax, multiple</u></p> <p>DUE TO (c) <u>& Multiple Deficiencies of Myocardium</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)</p> <p>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</p> <p style="text-align: right;">INTERVAL BETWEEN ONSET AND DEATH <u>40 min.</u></p>								
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>		<p>20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/></p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)</p>				
<p>20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year</p>		<p>20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>20f. CITY, TOWN, OR LOCATION COUNTY STATE</p>		
<p>21. I attended the deceased from <u>11-11-62</u> to <u>11-11-62</u> and last saw ^{her}him alive on <u>11-11-62</u></p> <p>Death occurred at <u>4:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.</p>								
<p>22a. SIGNATURE (Degree or title) <u>[Signature]</u></p>				<p>22b. ADDRESS <u>M. D. 1515 Hazel, Carthage, Mo</u></p>		<p>22c. DATE SIGNED <u>11-12-62</u></p>		
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u></p>		<p>23b. DATE <u>11-13-62</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Diamond Cemetery</u></p>		<p>23d. LOCATION (City, town, or county) (State) <u>Diamond, Mo</u></p>		
<p>24. FUNERAL DIRECTOR ADDRESS <u>KNELL MORTUARY Carthage, Mo</u></p>			<p>25. DATE RECD. BY LOCAL REG. <u>11-12-62</u></p>		<p>26. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>			

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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 *Gene C. Pugh*

Licensed Embalmer No. 4231

P. O. Address Carthage, Mo.

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.