

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001358

STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 143 Primary Registration District No. 5560 Registrar's No. 85

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 29 1963

VS 300
Rev. 4/59

1 0460

2 0460

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9332X

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12 90-0

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Howell</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Howell</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Willow Springs Twp.</u> Length of stay in 1b <u>15 Yrs.</u>		c. CITY OR TOWN <u>Willow Springs,</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rt #1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEONORA ALEXINA BOTTOM</u>			4. DATE OF DEATH Month Day Year <u>Jan. 24, 1963</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/64</u>
9. AGE (last birthday) <u>98</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York State</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>David Mark</u>		13b. MOTHER'S MAIDEN NAME <u>Delilah Durfee</u>	14. NAME OF HUSBAND OR WIFE <u>Robt. C. Bottom</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>No</u>)		16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT Address <u>O.E. Bottom, Willow Springs, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular occlusion</u> DUE TO (b) <u>Arteriosclerosis generalized & Cerebral</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			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
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>Oct. 9, 1962</u> to <u>1/24/63</u> and last saw her ^{her} alive on <u>1/21/63</u> . Death occurred at <u>6:20 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Thomas L. Coffey M.D.</u>		22b. ADDRESS <u>Willow Springs, Mo.</u>	22c. DATE SIGNED <u>1/25/63</u> (State)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/28/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Epps</u>	
23d. LOCATION (City, town, or county) <u>Pomona, Mo.</u>		24. FUNERAL DIRECTOR ADDRESS <u>Burns - Willow Springs, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>1/26/63</u>		26. REGISTRAR'S SIGNATURE <u>Tracy Boos</u>	

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 T.R. Burns



Licensed Embalmer No. 4214

P. O. Address Willow Springs, 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.