

NEW PINK UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully applied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

PLACE OF DEATH
 County Jackson
 Township Kaw
 or
 Village _____
 or
 City Kansas City (NO South Side Hospital St. _____ Ward) _____
 Registration District No. 399
 File No. 29806
 Primary Registration District No. 1002
 Registered No. 2905
 FULL NAME Mrs Lillie M. Butler
 (If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED widow
 WIDOWED OR DIVORCED
 (Write the word)

DATE OF BIRTH Nov 28 1874
 (Month) (Day) (Year)

AGE about 3 39 yrs. _____ mos. _____ ds. IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Occupation Operator of Sewing Machine in Mattress Factory
 (b) General nature of industry, business, or establishment in which employed (or employer) Acme Bedding Co.

BIRTHPLACE (City or town, State or foreign country) Fairgrove Missouri

PARENTS

NAME OF FATHER <u>Chas J. Lion</u>
BIRTHPLACE OF FATHER (City or town, State or foreign country) <u>Knoxville Tenn.</u>
MAIDEN NAME OF MOTHER <u>Margaret Rhea</u>
BIRTHPLACE OF MOTHER (City or town, State or foreign country) <u>Knoxville Tenn.</u>

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Sept 6 1913
 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 5, 1913, to Sept 6, 1913, that I last saw her alive on Sept 6, 1913, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH was as follows:
Shock
nephritis
1920

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (SECONDARY) Shock following operation
 (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) James Henderson M. D.
Sept 3 1913 (Address) 3615 Wobash

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted If not at place of death? _____

Former or usual residence _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Mrs M. Hoffman
 (ADDRESS) 1918 Robinson
 SEP -17 1913 Springfield Mo. Wheeler
 Filed _____ 1913
 REGISTRAR

PLACE OF BURIAL OR REMOVAL Springfield Mo.
 DATE OF BURIAL Sep 9 1913
 UNDERTAKER Dylar Bros
 ADDRESS 1401 Main St.

