

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

Do not use this space.

36733

1. PLACE OF DEATH *Jackson*
 County *Madison* Registration District No. *398*
 Township *Blue* Primary Registration District No. *7-1-9554*
 City *Madison* *Bridge Sanitarium* St. _____ Ward _____

2. FULL NAME *J. Foster Butler*
 (a) Residence No. *601 Glenwood Mt. Washington*
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred *20* yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Lucy A. Butler*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *June 3-1863*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
64 6 14

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Swatch Tender*
 (b) General nature of industry, business, or establishment in which employed (or employed by) *Stanger City Terminal*
 (c) Name of employer *Texas City*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Waverly Illinois*

PARENTS

10. NAME OF FATHER *J. C. Butler*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

12. MAIDEN NAME OF MOTHER *Riza Elliott*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT (Address) *Mrs. Lucy Butler 601 Glenwood*

15. FILED *Dec 20 1927 F. G. Cook* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *12-17-1927*

17. I HEREBY CERTIFY, That I attended deceased from _____
11-28, 19*21*, to _____
12-17, 19*27*, and that I last saw him alive on _____
12-17, 19*27*, and that death occurred, on the date stated above, at _____
8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Thromboplegia apoplexy
 (duration) _____ yrs. mos. *3* ds.
 CONTRIBUTORY *Myocarditis, Hypertension*
 (SECONDARY) (duration) *3* yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? *906*

19. DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

20. WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *none*

(Signed) *George R. Park*, M. D.

12-17-1927 (Address) *Englewood Mo.*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

Mt. Washington 12-19-27

20. BURIED BY *ON LEARSONSON* ADDRESS *Lucy 700*

N. B.—Every item of information should be carefully supplied. 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.

