

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

Do not use this space.

PR 24 1020

✓ 10165

1. PLACE OF DEATH

County Dunklin
Township Blaney
City (No.) St. Ward)

Registration District No. 287
Primary Registration District No. 5405

File No.
Registered No. 7

2. FULL NAME

Lena Leona Butts

(a) Residence No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female | white | single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Not Known

7. AGE YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.
About 33 years old.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employes) Laboring
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Sharp. Co. Ark.

10. NAME OF FATHER Clarence Butts

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ill. Mo.

12. MAIDEN NAME OF MOTHER Rosa Carson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Sharp. Co. Ark.

14. INFORMANT (Address) U. O. Butts
Hornersville Mo. R.F.D. #1

15. FILED 3-11-29 19.....
E. G. Cope REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 17 1929

17. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at 7:30 A.M.

THE CAUSE OF DEATH** WAS AS FOLLOWS:
Hemorrhage from uterus
141
14-17-1929 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH:.....

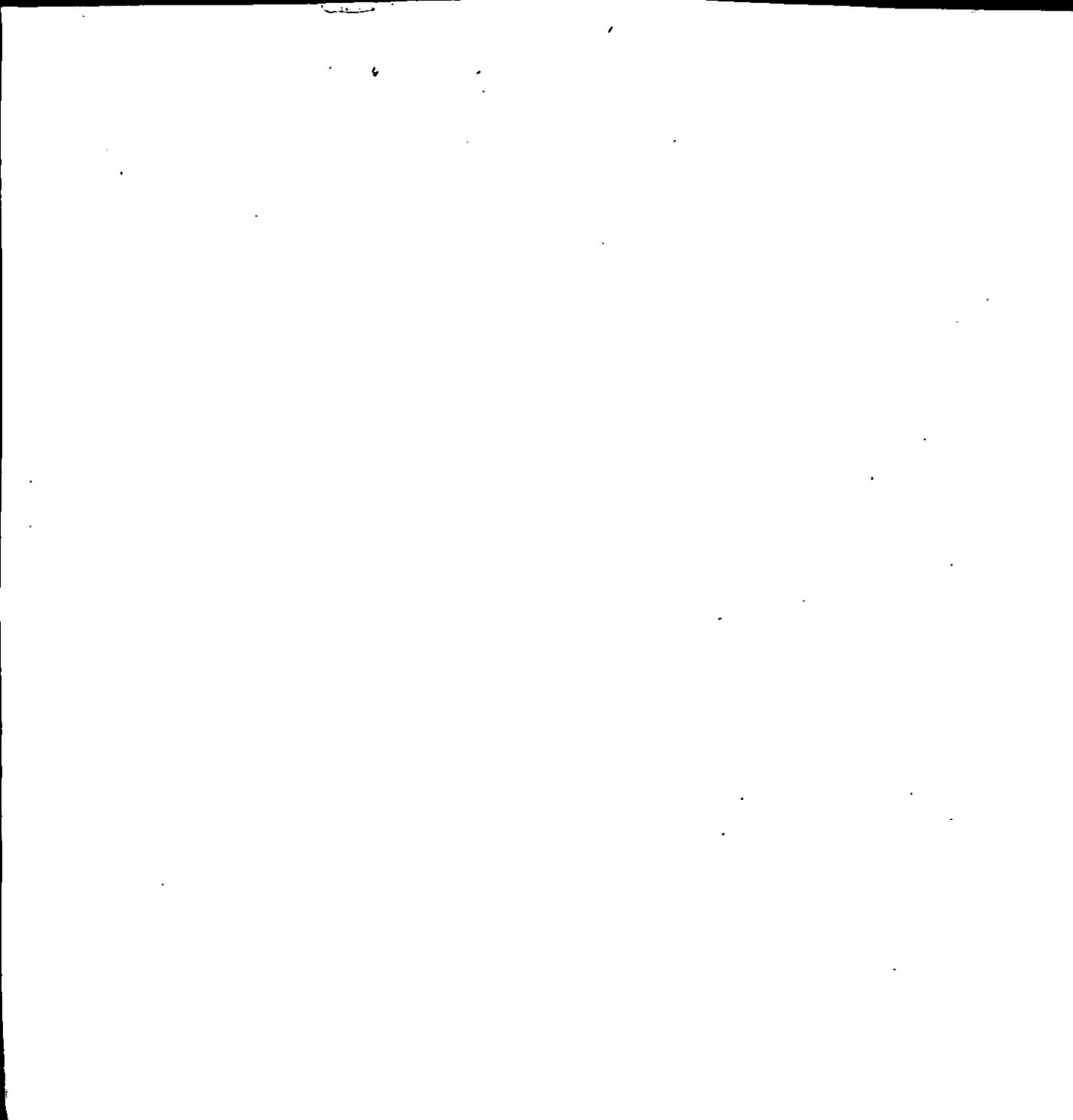
8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. P. Murrell Corner M. D.
19 (Address) Kennett

*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
Hornersville Cemetery Mar. 12 1929

20. UNDERTAKER ADDRESS
M. Daniel per Co Senath Mo.



**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
 County Dunklin Registration District No. 287 File No. 10165
 Township Way Primary Registration District No. 3404 Registered No. 7
 City..... (No.) St. Ward)

2. FULL NAME Eva Leona Butler
 (a) Residence. No. St. Ward.
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (after the word) <u>S</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer				
9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
PARENTS	10. NAME OF FATHER			
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)			
	12. MAIDEN NAME OF MOTHER			
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)			

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 12 1929

17. I HEREBY CERTIFY That I attended deceased from 19..... to 19..... that I last saw h..... alive on 19..... and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septicæmia from (Petersen) from meningitis
 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH
 DID AN OPERATION PRECEDE DEATH? DATE OF
 WAS THERE AN AUTOPSY?
 WHAT TEST CONFIRMED DIAGNOSIS?
 (Signed)....., M. D.
 , 19 (Address)

*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.

14. INFORMANT (Address)	19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
15. FILED <u>5/12/29</u> 19..... <u>E. G. Cap...</u> REGISTRAR	20. UNDERTAKER	19..... ADDRESS

SUPPLEMENTARY

A FEE FOR CERTIFICATES UNTIL THEY ARE CONFIRMED BY REGISTERED DEATH IN STAT. SERVICE A FEE FOR INFORMATION

5-10165