

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

Do not use this space.

1476
471

1. PLACE OF DEATH

County Jackson Registration District No. 399
Township Blue Primary Registration District No. 1002
City Leeds Leeds Hospital

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Butler Alice
(a) Residence. No. 2925 Jarboe St. 3 Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>Negro</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>widow</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 22/1909</u>		
7. AGE	YEARS <u>20</u>	MONTHS <u>7</u>
	DAY <u>8</u>	IF LESS than 1 day, _____ hrs. or _____ min.
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work. <u>Laundress</u> (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) <u>Oklahoma</u>		
PARENTS	10. NAME OF FATHER <u>M^r Lee N. J.</u>	
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Mississippi</u>	
	12. MAIDEN NAME OF MOTHER <u>Noland Nora</u>	
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) <u>Arkansas</u>	
14. INFORMANT <u>K. E. T. B. Hospital</u> (Address) <u>Leeds, Mo</u>		
15. FILED <u>2/1</u> 19 <u>30</u> <u>M. M. Crows</u> REGISTRAR		

MEDICAL CERTIFICATE OF DEATH

1. 1

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-30-1930

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1930 to Jan. 30, 1930 that I last saw her alive on Jan. 30, 1930, and that death occurred, on the date stated above, at 9:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Pulmonary Tuberculosis

238 (duration) 0 yrs. 4 mos. ds.

CONTRIBUTORY (SECONDARY) none (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH unknown
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Chargaff's test
(Signed) Edwin P. ... M. D.
Jan 30, 1930 (Address) 1880 Vine St

*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
West Lawn Cemetery Feb. 1 1930

20. UNDERTAKER ADDRESS
West Apptn Co 1600 E. 19th

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.

238
2

