

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

Do not use this space.

18802

1. PLACE OF DEATH

County Laclede Co
 Township Fulton
 City Fulton Mo (No. _____)

Registration District No. 104
 Primary Registration District No. 3008

File No. _____
 Registered No. 141 St. _____ Ward)

2. FULL NAME

Frank Butler (Butts)
 (a) Residence. No. State Hospital No St. _____ Ward. Berkley Green Rd
 (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

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
44, 83 — —

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work DK
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) DK
 (STATE OR COUNTRY) _____

10. NAME OF FATHER DK
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) DK
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER DK
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) DK
 (STATE OR COUNTRY) _____

14. INFORMANT Conroy Hospital No 1
 (Address) Fulton Mo

15. FILE NO. 6-24-19-30 R. M. Creas
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 24 1930
 17. I HEREBY CERTIFY, That I attended deceased from _____ to _____
 that I last saw him alive on June 23 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Arterio Sclerosis
 (duration) _____ yrs. _____ mos. _____ ds.
 CONTRIBUTORY (SECONDARY) Myocardial Infarction
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED DK
 IF NOT AT PLACE OF DEATH _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN ALDOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS? As limited
 (Signed) DK, M. D.
 . 19 State Hospital No 1

*State the DISEASE CAUSING DEATH, or in death from Voluntary Causes, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL State Hoop Grounds DATE OF BURIAL 6/24 1930

20. UNDERTAKER J J Tobey Fulton Mo State Hoop ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

14
 1930

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