

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

Do not use this space.

30447

1. PLACE OF DEATH

County Osage Registration District No. 643
 Township Jefferson Primary Registration District No. 556
 City Jefferson (No. _____) St. _____ Ward _____

2. FULL NAME

Chester Butler
 (a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 2 - 1932
 7. AGE YEARS 13 MONTHS 1 DAYS 30 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farm
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. bay
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MOTHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osage Co Mo
 FATHER 13. NAME Jack Butler
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osage Co Mo
 15. MAIDEN NAME Julia Phelps
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Osage Co Mo

17. INFORMANT (ADDRESS) _____
 18. BURIAL, CREMATION, OR REMOVAL PLACE Mem Zion DATE Sept 2 1933
 19. UNDERTAKER (ADDRESS) 5074 Slickley
Osage Mo
 20. FILED Nov 10 1933 Removal
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 1 1933

22. I HEREBY CERTIFY, that I attended deceased from Aug 27 1933, to Sept 1 1933

I last saw him alive on Aug 31 1933 Death is said

to have occurred on the date stated above, at 9 a. m.

The principal cause of death and related causes of importance were as follows:

Typhoid
 Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____

(Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) C. D. Bunge, M. D.

(Address) Beard Mo

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.

NOV 10 1933

