

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

Do not use this space.

1. PLACE OF DEATH

County Butler Registration District No. 50 File No. 15692
 Township _____ Primary Registration District No. 3004 Registered No. 36
 City Butler (No. Butler Memorial Hospital St. _____ Ward _____)

2. FULL NAME

(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

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Aug 11th 1850</u>		
7. AGE	YEARS <u>83</u>	MONTHS <u>9</u>
	DAYS <u>28</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	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) <u>don't know England</u>	
	13. NAME <u>don't know</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>don't know</u>	
	15. MAIDEN NAME <u>don't know</u>	
FATHER	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>don't know</u>	
	17. INFORMANT (ADDRESS) <u>E. J. Groat Butler Mo</u>	
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Oak Hill</u> DATE <u>May 10th 1934</u>		
19. UNDERTAKER (ADDRESS) <u>Butler Mo</u>		
20. FILED <u>May 11, 1934</u> <u>Min P. Culver</u> Registrar		

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 9, 1934

22. I HEREBY CERTIFY, That I attended deceased from May 3, 1934 to May 9, 1934
 I last saw him alive on May 9, 1934 Death is said to have occurred on the date stated above, at 12:30 P.M.
 The principal cause of death and related causes of importance were as follows:
Bronch. pneumonia
Gas Gangrene
Bacillus Welchii
 Other contributory causes of importance:
Infection Bacillus Welchii

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.

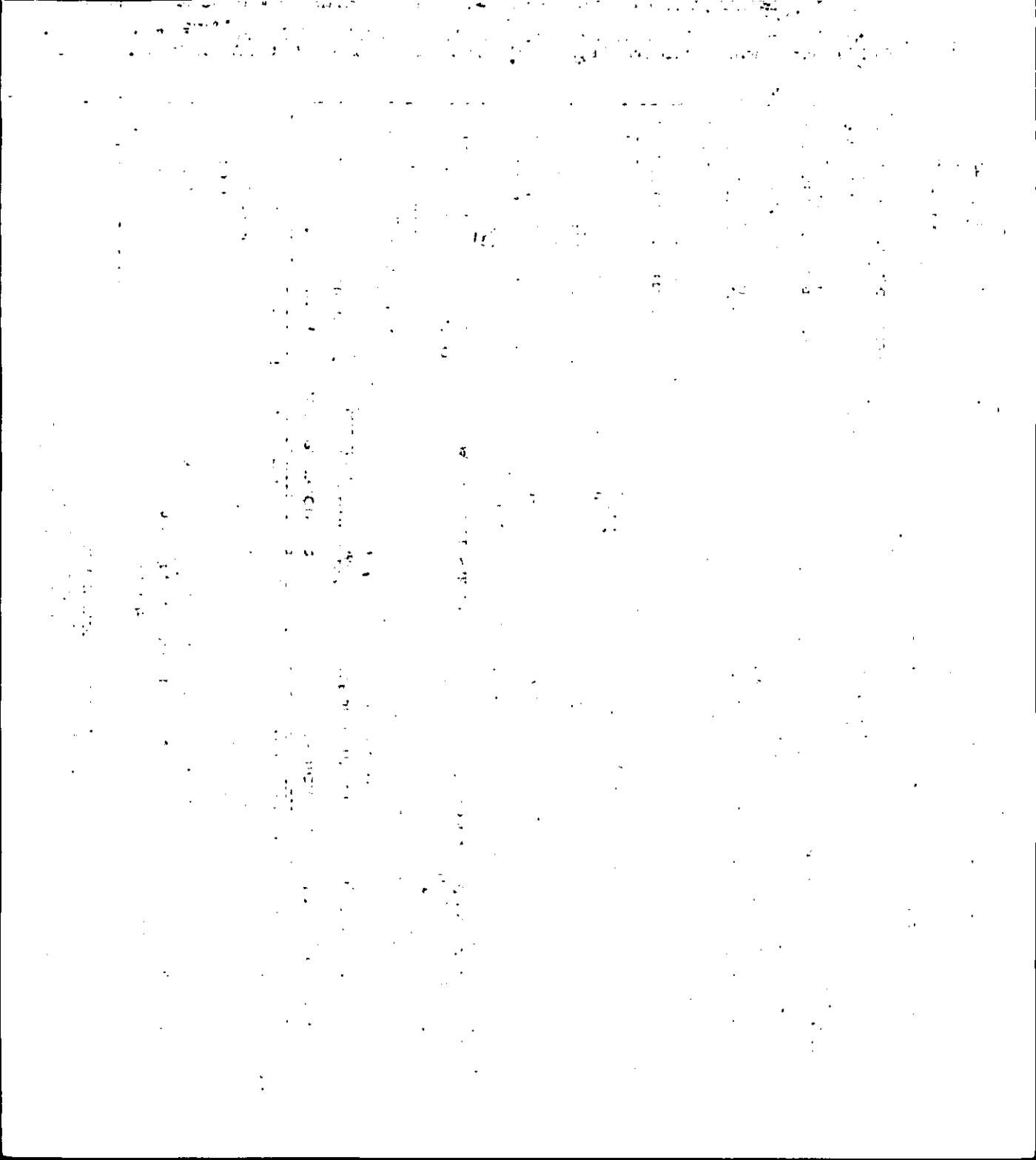
Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify Carter W. Luter, M. D.
 (Signed) _____ (Address) Butler 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.

JUN 20 1934



#2 *Batts*
Butler

DEPARTMENT OF COMMERCE

E. T. McGaugh, M. D.,
Special Agent,
Jefferson City, Mo.

BUREAU OF THE CENSUS 15692

WASHINGTON

36

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Charles Grant

Who died at Memorial Hosp. on May-9-1934

Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex M Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 83 Months 9 Days 28

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) _____

Birthplace of mother (State or country) _____

Principal cause of death: Broncho Pneumonia - Gas Gangrene
Bacillus Welchii (Gas Bacillus is an infection)
not diabetes

Other contributory causes of importance Infection Bacillus Welchii

Name of operation _____ Date of _____

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

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 _____

Was disease or injury in any way related to occupation of deceased? 34

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Nina L. Carter Date filed Sept. 4. 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Reg. Dist. "o. 50

Very truly yours,

Primary Reg. Dist. No. 3004

E. T. McGaugh, M.D.
Special Agent. K.

RECEIVED

NOV 19 1952

AMERICAN

S-15692

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