

DEC 20 1937

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

41581

Do not use this space.

## 1. PLACE OF DEATH

(a) County Jasper Registration District No. 411  
(b) Township \_\_\_\_\_ Primary Registration District No. 2002 Registered No. \_\_\_\_\_  
(c) City Joplin (d) Street No. St. John's Hospital St. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. 10 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

Basil Buterbaugh  
(a) Residence, No. Route 4, Carthage St.  Carthage, Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city of town and State)

## PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 7, 1898

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
39 5 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Powder Plant Assistant Supervisor  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Maple Grove Missouri

FATHER 13. NAME Martin Buterbaugh

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

MOTHER 15. MAIDEN NAME Elizabeth Stocker

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

17. INFORMANT (ADDRESS) Mrs. Jewell Buterbaugh Route 4, Carthage, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Park Cemetery DATE Nov. 13, 1937

19. FUNERAL DIRECTOR (ADDRESS) Ulmer Funeral Home Carthage, Missouri

20. FILED 11-13-37 [Signature] Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 11, 1937

22. I HEREBY CERTIFY, That I attended deceased from 11-1-37, 19, to 11-11-37, 19

I last saw him alive on 11-10-37, 1937 Death is said

to have occurred on the date stated above, at 4:00am

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

Lung Abscess approx 9-30-37

Other contributory causes of importance:

Pulmonary Embolism 11-10-37

Name of operation Bronchotomy 11-1-37 Date of 11-6-37

What test confirmed diagnosis? X-Ray Was there an autopsy? NO

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? NO  
If so, specify \_\_\_\_\_

(Signed) [Signature], M. D.

(Address) 407 Travis St. Joplin Mo

114B

JAN 3 1955

STATEMENT BY LICENSED EMBALMER

I, Ed C. Ulmer, Licensed Embalmer No. 2222

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Ed C. Ulmer

Licensed Embalmer No. 2222

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

Vertical text on the right edge of the page, including "CCF BY (M)" and other illegible characters.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH

(a) County Jasper Registration District No. 411  
 (b) Township Joplin Primary Registration District No. 2002 Registered No. \_\_\_\_\_  
 (c) City Joplin (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Estil Buterbaugh

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.  
39 5- 4

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED \_\_\_\_\_ 19\_\_\_\_

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 11 1937

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Large abscess  
Pyogenic  
not I.B.  
not mechanical  
1143 in Bureau  
may have been  
respiratory

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) Winifred L. Paat, M. D.

(Address) 407 First St. Joplin Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

