

1939 MAR 13

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

5987
Do not use this space.

1. PLACE OF DEATH

(a) County BUCHANAN Registration District No. 85
(b) Township WASHINGTON Primary Registration District No. 1001 Registered No. 198
(c) City ST. JOSEPH (d) Street No. 411 MICHIGAN 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 62 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME SARAH JANE BUTRICK

(a) Residence, No. 411 MICHIGAN AVENUE 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 FEMALE 4. COLOR OR RACE WHITE 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) WIDOWED

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF SAMUEL N. BUTRICK

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) MAY 9, 1857

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
81 9 18

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWIFE
9. Industry or business in which work was done, as saw mill, bank, etc. UNKNOWN
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) ST. JOSEPH, MISSOURI

FATHER 13. NAME UNKNOWN WALKER,
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) CONNECTICUT

MOTHER 15. MAIDEN NAME UNKNOWN
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN

17. INFORMANT (ADDRESS) MRS. CHAS. A. ENOS, 1918 LOVERS LANE, ST. JOSEPH,

18. BURIAL, CREMATION, OR REMOVAL PLACE ASHLAND CEMETERY, DATE MARCH 1, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON, INC. 1946 COLHOUN ST ST. JOSEPH, MO.

20. FILED Mar. 1, 1939 H. J. Nestlebrook Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) FEB, 27, 1939 19

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1938 to Feb 27, 1939
I last saw h. ER. alive on Feb 27, 1939 Death is said to have occurred on the date stated above, at 6:00 P.M.

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

arterio sclerosis, general
Langens
Other contributory causes of importance:
Gangrene left foot
myocarditis, chronic

Date of onset

Dec. 1938

Name of operation none Date of _____
What test confirmed diagnosis? clinical 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.

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) C. Grant M.D. M. D.
(Address) St. Joseph, Mo.

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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, JOHN E. RUPP

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

John E. Rupp

Licensed Embalmer No.....

3986

P. O. Address.....

St Joseph, Mo

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

If this body is not embalmed, above space should be left blank.