

K. 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.

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

26718
 Do not use this space.

AUG 14 1939

1. PLACE OF DEATH

(a) County St. Francois Co. Registration District No. 773
 (b) Township St. Francois Primary Registration District No. 6018A
 (c) City near Farmington (d) Street No. State Hospital No. 4 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. da. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 320 Tony Butts

(a) Residence, No. Jefferson Co. Farm St.
 (Usual place of abode, if no street address, write county or city) (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 Single		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Un.		
7. AGE	YEARS 75	MONTHS Un.
		DAYS Un.
		If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as Sawyer, bookkeeper, etc. None	
	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)	Un.	
FATHER	13. NAME Un.	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown	
MOTHER	15. MAIDEN NAME Un.	
	15. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown	

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7-9** 19 **39**

22. I HEREBY CERTIFY, That I attended deceased from **5-22** 19**39**, to **7-9** 19**39**

I last saw h. **im** alive on **7-8** 19**39**. Death is said to have occurred on the date stated above, at **7:45a.m.**

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

Cerebral Arteriosclerosis with psychomotor (Cold right hemiplegia) with terminal embolism

Chronic Nephritis Coronary Arteriosclerosis Chronic Myocarditis Chronic fibrous pleurisy (left)

Name of operation **None** Date of **None**
 What test confirmed diagnosis? **Clin. & Lab** Was there an autopsy? **Yes**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **None** Date of injury **None** 19**39**

Where did injury occur? **None** (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **None**
 Nature of injury **None**

24. Was disease or injury in any way related to occupation of deceased? **No**
 If so, specify **None**

(Signed) **G. T. Graves**, M. D.
 (Address) **Farmington, Mo.**

17. INFORMANT **Records of State Hospt. #4**
 (ADDRESS) **Farmington, Mo.**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **State Hospt. #4** DATE **7-10** 19**39**

19. FUNERAL DIRECTOR (NAME) **C. Hugo Cozean**
 (ADDRESS) **Farmington, Mo.**

20. FILED **July 9 1939** **B. J. Robinson**
 Local Registrar.

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, or by.....

me

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

C. Hugo Cozart

Licensed Embalmer No.....

4084

P. O. Address.....

Lammington

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.