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.

SEP 12 1939

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

Hall 29140
Do not use this space.

1. PLACE OF DEATH

(a) County GREENE — Registration District No. 318

(b) Township — Primary Registration District No. 2001 — Registered No. 622

or

(c) City SPRINGFIELD — (d) Street No. 823 State 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 James Henry Butler

(a) Residence, No. 823 State 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): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(OR) WIFE OF~~ Mary G. Butler

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 16 - 1868

7. AGE: YEARS 70 — MONTHS 9 — DAYS 24 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Truck driver
9. Industry or business in which work was done, as saw mill, bank, etc. Transfer Co.
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) Marionville Mo

FATHER

13. NAME James K. Butler
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shelbyville Tenn.

MOTHER

15. MAIDEN NAME Sally Terry
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn

17. INFORMANT (ADDRESS) Mary G. Butler Springfield Mo.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ PLACE Marionville Cem Mo DATE 8-12 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Alvin Lohmeyer Springfield Mo.

20. FILED Aug 12 1939 Chas A George MD Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug - 10 1939

22. I HEREBY CERTIFY, That I attended deceased from May 22, 1939, to Aug 10, 1939

I last saw him alive on Aug 10, 1939. Death is said to have occurred on the date stated above, at 1:50 A.m.

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

	Date of onset
Carcinoma Lower Lip	1937

H5

Other contributory causes of importance:

Metastases to Lungs	1939

Name of operation X ray Date of 1/39

What test confirmed diagnosis? Biopsy 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) Durward G. Hall, M. D.

(Address) 500 Holland Bldg. Springfield, Mo

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(Licensed Embalmer's Statement on Reverse Side)

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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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

X