

JUL 1 APR 27 1940

Registration District No. 68

Primary Registration District No. 0703

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Bollinger
(b) City or town Burnett (Crested Creek)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Malinda J. Butler

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife R. K. Butler (c) Age of husband or wife if alive 64 years

7. Birth date of deceased Oct 4 1878
(Month) (Day) (Year)

8. AGE: Years 61 Months 7 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Essex (City, town, or county) MO (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name Ebenezzer Trotter
13. Birthplace Illinois (City, town, or county) (State or foreign country)
14. Maiden name Ellen Hull
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Malinda J. Butler
(b) Address Burnett Mo

17. (a) _____ (b) Date thereof Feb 20 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Church

18. (a) Signature of funeral director Harold Gray

(b) Address Marionville Mo

19. (a) Apr 8 1940 (b) Burnett Mo
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Bollinger

(c) City or town Burnett
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 19
year 1940 hour 5 minute 0 A. M.

21. I hereby certify that I attended the deceased from 2/19/40
_____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Decompensation Duration _____

Due to Gastric Hemorrhage

Due to Malignancy

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature John J. Myers (M. D. or other) _____

Address St Louis Mo Date signed 2/19/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Rev. 5-17-39

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.

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Robert J. ...

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 comply with the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 10130

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 68

Primary Registration District No. 5103

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Bollinger

(b) City or town Crossed Creek
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME Malinda J. Butler

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex 7 5. Color or race _____

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

61 4 11 _____ hr. _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

20. DATE OF DEATH: Month Feb day 19
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Deception
Insensation

Due to gastric Hemorrhage

Due to malignancy of stomach

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 4/6

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature J. D. ... (of D. or other) _____

Address _____ signed

SUPPLEMENTAL

MEDICAL CERTIFICATION

PHYSICIAN
Underline the cause to which death should be charged statistically.

S-10130 1940