

No. 2
17-39
X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32097
Registrar's No. 753

Registration District No. 318

Primary Registration District No. 5440

1. PLACE OF DEATH:
(a) County Greene *S. Campbell St*
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Medical Center for Federal Prisoners
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 Month 23 Days
(Specify whether
In this community 1 Month 23 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Alabama (b) County Russell
(c) City or town Phenix City
(If outside city or town limits write "RURAL")
(d) Street No. Route 2, Phenix City, Ala.
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME BUTTS, Glen
(b) If veteran, name war None
(c) Social Security No. Unknown

4. Sex Male
5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (c) Age of husband or wife if alive XX years
7. Birth date of deceased Feb. 7 1912
(Month) (Day) (Year)

8. AGE: Years 28 Months 7 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation Laborer

11. Industry or business Unknown

MOTHER FATHER
12. Name Will Butts
13. Birthplace Russell County Alabama
(City, town, or county) (State or foreign country)
14. Maiden name Pearl Thomas
15. Birthplace Phenix City Alabama
(City, town, or county) (State or foreign country)
16. (a) Informant Deceased

(b) Address _____

17. (a) Removal (b) Date thereof 9-17-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbus Ga.

18. (a) Signature of funeral director Alma Robinson

(b) Address Springfield, Mo.

19. (a) Sept 17, 1940 (b) W. E. Handley MD
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 15th,
year 1940 hour 9:00 minute _____ A.M.

21. I hereby certify that I attended the deceased from July 23, 1940
_____ 19____ to Sept. 15, 1940
that I last saw him alive on Sept. 15, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis, Tuberculous
Duration Since Adm.

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy Yes
Diagnosis verified by Clinical Rec.

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

23. Signature L. M. Rogers, Surgeon (M. D. or other) _____
Address Clinical Director MCFP Date signed _____

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

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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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32097**
Registrar's No. **753**

Registration District No. **318**

Primary Registration District No. **5440**

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

1. PLACE OF DEATH:

(a) County **Greene**
(b) City or town **Campbell T.P.**
(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.....
years, months or days)

3. (a) PRINT FULL NAME **Glen Butts**

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

4. Sex **M** 5. Color **Cal** 6. (a) Single, widowed, married, divorced, **single**

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 **28** Months **7** Days **8** If less than one day..... min.

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

10. Usual occupation.....

11. Industry or business.....

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..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) **NOV 25 1940** (b) **W. E. Handley MD** (c) 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 **Sept** day **15** year **1940** hour..... minute..... M.

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

Immediate cause of death **Tuberculous peritonitis**
Tuberculous of peritoneum & intestines

Due to.....
Due to.....

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

Major findings: Of operations.....
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) (e) Means of injury.....

23. Signature **F. M. Rogers** (M. D. or other)
Address **Springfield Mo** Date signed.....

SUPPLEMENTARY

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

