DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAY 12 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14963

Registration District No. 567 Primary Registration District No. 5767 Registrar's No.

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

1. PLACE OF DEATH:

(a) County MISSISSIPPI

(b) City or town WOLF ISLAND Twp (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: EAST PRAIRIE R#2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community 3 MONTHS

2. USUAL RESIDENCE OF DECEASED:

(a) State ARKANSAS (b) County POINSETT

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

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

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country NONE

3. (a) PRINT FULL NAME DAVE CROUCH ~~CROWD BUTLER~~

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex MALE

5. Color or race COLOR

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

6. (b) Name of husband or wife NONE

6. (c) Age of husband or wife if alive NONE years

7. Birth date of deceased JAN (Month) 1 (Day) 1894 (Year)

8. AGE: Years 48 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation DAY LABORER

11. Industry or business Public WORK

FATHER
12. Name MARIED BUTLER
13. Birthplace STATE OF MISSISSIPPI (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name FLORENCE HOPSON
15. Birthplace STATE OF MISSISSIPPI (City, town, or county) (State or foreign country)

16. (a) Informant ROBERT BUTLER
(b) Address WOLF ISLAND, Mo c/o E.A. STORY

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-19-42 (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE-CHARLESTON, Mo

18. (a) Signature of funeral director John D Nunnelee Jr
(b) Address CHARLESTON, Mo

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 19TH year 1942 hour 12 minute 17 A.M.

21. I hereby certify that I attended the deceased from Mch 15 Mch 15, 1942, to Mch 19, 1942 that I last saw him alive on Mch 15, 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of Bone

Due to Pneumonary Tuberculosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 13 b'

Of autopsy

Duration 2 yrs.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature S P Martin (M. D. ~~or other~~)

Address East Prairie Mo Date signed 3-19-42

1271

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 442-489
Date Filed 4-13-42

Body Not Embalmed

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 wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

State of Mo } ss.
County of Mississippi

AFFIDAVIT FOR CORRECTION OF A RECORD

State File No.
Local Registrar's No.

On this 20th day of May, 1942, before me appears FLORENCE ALLEN, who, upon HER oath, states that the original record of ~~birth~~ death for DAVID CROWD BUTLER, ~~born~~ died March 19, 1942 in the State of Missouri, and which was filed at EAST PRAIRIE, MO in MARCH, 1942, should be corrected as follows:

Item No. 3a should read Dave Crouch
Instead of David Crowd Butler

Item No. should read
Instead of

Item No. should read
Instead of

Item No. should read
Instead of

Item No. should read
Instead of

Item No. should read
Instead of

Item No. should read
Instead of

Item No. should read
Instead of

The above is true to the best of my knowledge, information and belief.

(SEAL)

Affiant. Florence Allen
Relationship. MOTHER

WOLF ISLAND, MO c/o E.A. STORY
Present Address.

Subscribed and sworn to before me this 20th day of May, 1942.

My Commission expires
My commission expires January 25, 1946.

John F. Mummelee Jr
Notary Public.

Affidavits containing erasures will not be accepted; draw one line through error and write above it.

m V. S. 135
DM 9-4-41
I X29483

V. S. No. 2B
0M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14963

Registration District No. 5-67 Primary Registration District No. 5767 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Mississippi

(b) City or town Wolf Island
(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Poinsett

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

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dave Crouch

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Jan -1- 1894
(Month) (Day) (Year)

8. AGE: Years 48 Months 2 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

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

19. (a) 5-9-42 (Date received local registrar) (b) Fannie E. Bugman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mch day 19
year 1942 hour 12 minute 17 a.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 Tuberculosis of bone, pneumonary Tuberculosis

Due to

Due to 13 b 1

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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

23. Signature (M. D. or other)
Address Date signed