

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

Registrar's No.

Registration District No. **791**

Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
St. Mary's Infirmary  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 hrs. 20 min.  
(Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. 4135 a Finney  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME Ronald Butler

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

4. Sex Male 5. Color or race negro 6. (a) Single, widowed, married, divorced, minor

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 10 1942  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>4 hr. 20 min.</u>

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10  
year 1942 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from 7-10-42  
4:00 P.M. 19   to 7-10-42 9:20 P.M.  
that I last saw him alive on 7-10-42 19    
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to Intra-cranial Hemorrhage

Due to Prolonged Effluent Posterior

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

9. Birthplace St. Louis 0 Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Allen Butler

13. Birthplace St. Louis 0 Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Justine Jackson

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

16. (a) Informant St. Mary's Infirmary  
(b) Address 15361 Papay

17. (a) Burial (b) Date thereof 7/3/42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation City Cemetery

18. (a) Signature of funeral director Wm Hamilton  
(b) Address City, Hazel Dept

19. (a) JUL 29 1942 (b) J. H. ...  
(Date received for registration) (Registrar's signature)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Intra-cranial Hemorrhage between skull & brain

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 J. S. ... (M. D. or other) M.D.  
Address 1526 Papay Date signed 7-13-42

**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, fact should be so stated above.**