V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 6 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 16489

Registration District No. 44

Primary Registration District No. 3008

Registrar's No. 165

14
1
2

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1Y-7M-27d (Specify whether years, months or days)

In this community 1Y-7M-27d

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline

(c) City or town Gilliam 14
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? No 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Sarah M. Davis

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F 1

5. Color or race W

6. (a) Single, widowed, married, divorced Widow 9

6. (b) Name of husband or wife

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

7. Birth date of deceased March (Month) 14 (Day) 1869 (Year)

8. AGE: Years 76 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Saline County, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Adam Harrison Butts
13. Birthplace Ky (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name Sophie Dye
15. Birthplace Ky (City, town, or county) 1 (State or foreign country)

16. (a) Informant J. W. Butts (brother)

(b) Address 421 S. 6th St., Enid, Okla.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof May 16-1945 (Month) (Day) (Year)

(c) Place: burial or cremation Slater City Cemetery

18. (a) Signature of funeral director Jones & Salzer

(b) Address Slater Mo.

19. (a) May 16-1945 (Date received local registrar) (b) Jose Morsinkhoff (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month May day 15 year 1945 hour 5:15 minute P M.

21. I hereby certify that I attended the deceased from 10-18-, 1945, to 5-15-, 1945; that I last saw him alive on 5-15-, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to arterio sclerosis

Due to

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 K. E. Shirrill (M. D. or other)

Address Fulton Mo. Date signed 5/16/45

(Licensed Embalmer's Statement on Reverse Side)

109 West 7th
Mason Sion Kirkoff

RECEIVED
District Health Officer No. 9,

District File Number.....

Date Filed 6-7-45

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 Herman Salzer

Licensed Embalmer No. 1831

P. O. Address Slater Missouri.

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.