

**FILED JUN 11 1945**

Registration District No. **317**

Primary Registration District No. **3069**

Registrar's No. **1292**

1. PLACE OF DEATH:

(a) County **St. Louis**  
(b) City or town **Richmond Heights**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Mary's Hospital**  
(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 **Sandra Kay Butler**

3. (b) If veteran, name war **Nil** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 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 **May 17 1944**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**1 0 17** hr. min.

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

10. Usual occupation **Infant**

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

MOTHER FATHER { 12. Name **Woodrow Butler**  
13. Birthplace **Unknown Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Huth Embrey**  
15. Birthplace **Niantick Illinois**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Frank Tippitt**  
(b) Address **Centralia, Ill.**

17. (a) **Removal** (b) Date thereof **6-5-45**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Centralia, Illinois**

18. (a) Signature of funeral director **Albert H. Hoppe**  
(b) Address **4700 Washington Blvd.**

19. (a) **JUN 6 1945** (b) **E. B. M<sup>rs</sup> Bourson MD**  
(Date received local certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Marion** **999**  
(c) City or town **Centralia** **11**  
(If outside city or town limits, write "RURAL") **0**  
(d) Street No. **721 W. Benick** **0**  
(If rural, give location)  
(e) Citizen of foreign country? **2** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **4**  
year **1945** hour **10** minute **A.M.**

21. I hereby certify that I attended the deceased from **May 22**, 19**45**, to **June 4**, 19**45**  
that I last saw her alive on **June 4**, 19**45**,  
and that death occurred on the date and hour stated above.

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

**Cortical atrophy**  
**157**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Encephalogram**  
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? \_\_\_\_\_

(e) Means of injury **D**  
23. Signature **[Signature]** (M. D. or other) **MD**  
Address **109 1/2 Maryland** Date signed **6/5/45**

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

**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 *Albert G. Hoffer*  
Licensed Embalmer No. *2971*

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.**