

U.S. No. 2
FORM-5-43
Rev. 5-17-39
X 36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 31 1945
Registration District No. 1003 Primary Registration District No. 1003
State File No. Registrar's No. 8705

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G Philips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 18 days
In this community 27 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 1117
(d) Street No. 2417 N Taylor
(If rural, give location) 9
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Daniel Butler
(b) If veteran, name war None
(c) Social Security No. 490-26-3850

4. Sex Male 2/5. Color or race Colored
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mollie Butler
6. (c) Age of husband or wife if alive 53 years
7. Birth date of deceased June 2 1881
(Month) (Day) (Year)

8. AGE: Years 64 Months 4 Days 2
If less than one day hr. _____ min. _____

9. Birthplace Murphysboro, Tenn.
(City, town, or county) (State or foreign country)
10. Usual occupation Janitor

11. Industry or business For several homes
12. Name Samuel Butler
13. Birthplace Unknown
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mollie Butler
(b) Address 2417 N Taylor
17. (a) Burial
(Burial, cremation, or removal) (b) Date thereof 10-12-45
(Month) (Day) (Year)
(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director C. J. Wash
(b) Address 1117 1/2 N Taylor
19. (a) OCT 9 1945
(Date received local registrar) (b) J. F. Bredeek
(Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 5
year 1945 hour 8 minute 20 P M.
21. I hereby certify that I attended the deceased from Sept. 17 1945 to Oct. 5 1945
that I last saw him alive on Oct. 5 1945
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

(1) Peritonitis (2) Adeno-Ca of Rectum
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____
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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Charles Attinson (M. D. or other)
Address 2601 S. Whitehall Date signed 10/9/45

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 C. J. Nash.....

Licensed Embalmer No. 2430.....

P. O. Address 111 N. 13th St......

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.