

FILED AUG 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24618
6525

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 30 yrs		2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			
11. STREET ADDRESS (If rural, give location) 2620 N. SARAH ST			

3. NAME OF DECEASED (Type or Print) Henry	a. (First)	b. (Middle)	c. (Last) Butler	4. DATE OF DEATH July 28 1950
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED	8. DATE OF BIRTH Feb. 16, 1906	9. AGE (In years last birthday) 44	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? USA		

13a. FATHER'S NAME Henry Butler	13b. MOTHER'S MAIDEN NAME Ida Smith	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Wesley Butler	ADDRESS 2620 N. SARAH ST
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH Undet
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma of left lung with Metastases		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Undetermined		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 162X
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22. I hereby certify that I attended the deceased from 6-6-1950, to 7-28-1950 that I last saw the deceased alive on 7-28-1950, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23. SIGNATURE M. J. Lawrence, D.	(Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 7-29-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 8-5-50	24c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM	24d. LOCATION (City, town, or county) (State) ST. LOUIS CITY, MO
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DATE REC'D BY LOCAL REG. JUL 31 1950	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE A. F. WALTON	ADDRESS 2707 STODDARD ST.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

M 1467 Bu

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4049 St Jershen

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.