

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 45229

FILED JAN 19 1954

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 12421

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 2117	
b. CITY (If outside corporate limits, write RURAL and give township) ST Louis		c. LENGTH OF STAY (In this place) 2 days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home G Phillips		e. STREET ADDRESS (If rural, give location) 11 1503 Whittier	
3. NAME OF DECEASED (Type or Print) Hazel		4. DATE OF DEATH (Month) (Day) (Year) Dec 31 1953	
a. (First) Hazel		b. (Middle) Guy	
c. (Last) Butler		5. SEX Female	
6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH 3 May 1905		9. AGE (In years last birthday) 48	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (City and State or Foreign Country) Little Rock, Ark		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME George Glass		13b. MOTHER'S MAIDEN NAME Virginia Payne	
14. NAME OF HUSBAND OR WIFE Silas Butler		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 S. Butler, 1503 Whittier, St Louis	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ ANTECEDENT CAUSES DUE TO (b) Cerebrovascular Accident Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Hemorrhage II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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)	
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? 331X		22. I hereby certify that I attended the deceased from _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:15 P.M., from the causes and on the date stated above.	
23a. SIGNATURE Patrick P. Taylor, Coroner		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 1-4-54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 6 Jan 1954		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) Berkeley, Mo		25. FUNERAL DIRECTOR'S SIGNATURE J. Coal Smith	
DATE REC'D BY LOCAL REG. JAN 4 1954		ADDRESS McBoyd Bros, Kinloch, Mo	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4444

P. O. Address St. Louis 13, Mo

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.