

FILED DEC 12 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36000**

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 1271			
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Buchanan					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 36 yrs.		c. CITY OR TOWN St. Joseph		d. Is Residence within limits of a city or incorporated town? XXX No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION 404½ Francis Street				e. STREET ADDRESS (If rural, give location) 404½ Francis Street <i>01170</i>					
3. NAME OF DECEASED (Type or Print) a. (First) Clarence			b. (Middle)		c. (Last) Butler		4. DATE OF DEATH (Month) (Day) (Year) Nov. 29 1955		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 2, 1886		9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipping Clerk			10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (City and State or Foreign Country) Sedalia, Missouri			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Robert Butler			13b. MOTHER'S MAIDEN NAME Lucy Moorhead			14. NAME OF HUSBAND OR WIFE Mrs. Dessie Butler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W. W. I.			16. SOCIAL SECURITY NO. 491-10-2132		17. INFORMANT'S SIGNATURE OR NAME Mrs. Dessie Butler ADDRESS 404½ Francis St. St. Joseph, Mo.				
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) Cardio Vascular Renal Disease INTERVAL BETWEEN ONSET AND DEATH 2 Mts ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 442X							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Oct 1 , 19 55 , to Nov 29 , 19 55 , that I last saw the deceased alive on Nov 28 , 19 55 , and that death occurred at 6:30P m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Arthur W. Craig M.D.				23b. ADDRESS 520 Francis St. St. Joseph, Mo.			23c. DATE SIGNED Nov 30, 1955		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec. 2-1955		24c. NAME OF CEMETERY OR CREMATORY Ashland Cemetery		24d. LOCATION (City, town, or county) (State) St. Joseph, Mo.			
DATE REC'D BY LOCAL REG. Dec 6, 1955		REGISTRAR'S SIGNATURE Kathleen M. Allison 485		25. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Alexander ADDRESS St. Joseph, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

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

DEC 14 1933

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..... *Wm. H. Alexander*

Licensed Embalmer No. *444*

P. O. Address *St. Joseph*

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.