

FILED NOV 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36111**XC-1865 50 56
RN 9957BIRTH NO. _____ REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Poplar Bluff		c. LENGTH OF STAY (In this place) 60 days	c. CITY OR TOWN Madison
d. FULL NAME OF HOSPITAL OR INSTITUTION VA Hospital		e. STREET ADDRESS (If rural, give location) 315 Weaver St.,	
3. NAME OF DECEASED (Type or Print) a. (First) G. b. (Middle) L. c. (Last) Tenie		4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1955	
5. SEX male	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 5-30-10
9. AGE (In years last birthday) 45		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10b. KIND OF BUSINESS OR INDUSTRY unknown	11. BIRTHPLACE (City and State or Foreign Country) Sledge, Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Saul Tenie	
13b. MOTHER'S MAIDEN NAME Mattie Tenie		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT'S SIGNATURE OR NAME VA Hospital Records		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Squamous cell carcinoma of the right buttock with metastasis		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 191X	
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) VA		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 Sept. 14, 1955 , to Nov. 13, 1955 , and that death occurred at 6:15A m. , from the causes and on the date stated above.	
23a. SIGNATURE E. D. BASKETT, MD., Chief Med. Sv.		23b. ADDRESS VAH, Poplar Bluff, Mo.	
23c. DATE SIGNED 11-14-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 11-16-55		24c. NAME OF CEMETERY OR CREMATORY Officers & Son	
24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.		25. FUNERAL DIRECTOR'S SIGNATURE Frank-Cotrell Poplar Bluff, Mo.	
DATE REC'D BY LOCAL REG. 11/19/55		REGISTRAR'S SIGNATURE [Signature]	

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

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
NOV 21 1955
BUTLER CO. HEALTH CENTER
FILE No. _____

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 *Joseph A. Beer* _____

Licensed Embalmer No. *296*

P. O. Address *Joseph A. Beer*

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.