

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-041367  
State File No. ....

14653 38  
FILED NOV 20 1958

BIRTH NO. REG. DIST. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10776

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		c. CITY OR TOWN <u>ST. LOUIS 13</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>DE PAUL HOSPITAL</u>		e. STREET ADDRESS (If rural, give location) <u>4771 MAFFITT AVE</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>DANIEL</u> b. (Middle) <u>-</u> c. (Last) <u>BUTLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 8, 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>	8. DATE OF BIRTH <u>NOV. 7, 1958</u>
9. AGE (In years last birthday) <u>18</u> Months <u>30</u> Days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>	
11. BIRTHPLACE (City and State or Foreign Country) <u>ST. LOUIS MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>RIDGEWAY A. BUTLER</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISE REID</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Louise Butler</u>	
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.		ADDRESS <u>4771 Maffitt</u>	

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) <u>a telecystitis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>762.5</u>				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>2</u> 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 11-7, 1958, to 11-8, 1958, that I last saw the deceased alive on 11-8, 1958 and that death occurred at 9:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Patricia Brennan M.D.</u>	23b. ADDRESS <u>111 Church</u>	23c. DATE SIGNED <u>11-8-58</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 10 1958</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>
24d. LOCATION (City, town, or county) (State) <u>St. Louis - Mo.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J.H. Randle &amp; Son</u>	
DATE REC'D BY LOCAL REG. <u>NOV 10 58</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	ADDRESS <u>3133 BELL AVE</u>

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 Not Embalmed....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.