

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019012  
STATE FILE NUMBER

XC 15840485  
SL 10664

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. **5037**

**JUN 4 1959**

300  
-57  
34  
7E

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY <b>ST CLAIR</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>915 N GRAND ST LOUIS MO</b>		c. CITY OR TOWN <b>EAST ST LOUIS</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VETS ADMIN HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>5 F GOMPER</b>	
Length of stay in 1b <b>40 days</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>ROBERT I BUTLER</b>			4. DATE OF DEATH Month Day Year <b>MAY 23, 1959</b>		
--	--	--	---	--	--

5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/3/07</b>	9. AGE (In years last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
-----------------------	----------------------------------	---	------------------------------------	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPE FITTER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>MONTGOMERY CITY, MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
---	-----------------------------------	--	--

13a. FATHER'S NAME <b>JIM BUTLER</b>	13b. MOTHER'S MAIDEN NAME <b>NORA MUDD</b>	14. NAME OF HUSBAND OR WIFE <b>ANN BUTLER</b>
---	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give major dates of service) <b>YES WW II</b>	16. SOCIAL SECURITY NO. <b>316-05-8903</b>	17. INFORMANT <b>VA HOSP RECORDS 915 N GRAND ST LOUIS MO</b>	Address
---	---	---	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA AND BILATERAL HYDROTHORAX</b>		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>EPIDERMOID CARCINOMA OF ESOPHAGUS WITH METASTASES TO PLEURA, LIVER AND LUNGS.</b>		<b>UNKNOWN</b>
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>150 X</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
---	--

20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
---	---	--	--

21. attended the deceased from <b>4/13/59</b> , to <b>5/23/59</b> and last saw him alive on <b>5/23/59</b> Death occurred at <b>10:45 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <b>ERNEST EGO AQUIRRE</b> (Degree or title)	22b. ADDRESS <b>M.D. VAH, ST LOUIS, MISSOURI</b>	22c. DATE SIGNED <b>5/24/59</b>
---	---	------------------------------------

23a. BURIAL, CREMATION, REBURY (Specify)	23b. DATE <b>MAY 27 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>	23d. LOCATION (City and state or county) <b>JEFFERSON BRKS MO</b> (State)
--	---------------------------------	---	--

24. FUNERAL DIRECTOR <b>Robins Funeral Home E. St Louis Ill</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>MAY 25 '59</b>	REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</b>
--	---------	---	---

*M. J. B.*

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

STATE OF MISSOURI  
DEPARTMENT OF HEALTH

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 *James Proff* .....  
Licensed Embalmer No. *4356*  
P. O. Address *St Louis 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.