URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-041640
STATE FILE NUMBER

AMENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210918

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2229 O'Fallon Apt 912
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2229 O'Fallon Apt 912
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First (Baby) Middle David Last Butler
4. DATE OF DEATH: Month 11 Day 23 Year 1959
5. SEX: Male
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11-9-59
9. AGE (last birthday) — IF UNDER 1 YEAR: Months — Days 14 — IF UNDER 24 HR: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - -
10b. KIND OF BUSINESS OR INDUSTRY: - -
11. BIRTHPLACE (City and state or country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY: USA
13a. FATHER'S NAME: Albert Butler
13b. MOTHER'S MAIDEN NAME: Eddie Lee Wesley
14. NAME OF HUSBAND OR WIFE: - -
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Albert Butler Address: - 2229 O'Fallon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 776X
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____ and last saw her/him alive on _____
Death occurred at 1140 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Patrick L. Taylor (Degree or title) Coroner
22b. ADDRESS: 1300 Clark
22c. DATE SIGNED: 11-24-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-27-59
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county): St. Louis (State): Mo.

24. FUNERAL DIRECTOR: Atkins Bros. ADDRESS: 3644 Finney Ave.
25. DATE RECD. BY LOCAL REG.: NOV 25 1959
26. REGISTRAR'S SIGNATURE: Hoard Smith, M.D. L.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by n

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed John F. Cunningha

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.