

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS DEC 5 1960

=60-041016

INDEXED

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 654

STATE FILE NUMBER

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Boone</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u> | | Length of stay in 1b <u>4 months</u> | c. CITY OR TOWN <u>Columbia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LEES REST HOME</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>15 W. Park</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | | |
|--|----------------------------------|---|--|---|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>BERTIE</u> Middle <u>BUTLER</u> Last <u>BUTLER</u> | | | 4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1960</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>negro</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-17-1891</u> | 9. AGE (last birthday) <u>69 yr.</u> | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HR Hours _____ Min. _____ |

| | | | | | | | |
|---|--|--|---|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and state or country) <u>Boone Co. Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13a. FATHER'S NAME <u>unknown</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Caroline Turner</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Harrison Butler</u> | |
| 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 <u>Arthur Butler, Columbia, Mo.</u> | | | |

| | | | |
|--|--|--|----------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> | | | <u>6 mo</u> |
| DUE TO (b) <u>Cerebral arteriosclerotic thrombosis</u> | | | <u>6 mo</u> |
| DUE TO (c) | | | |

| | | | |
|---|--|--|--|
| 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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
|---|--|--|--|

| | | | |
|---|---|--|-------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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. Month, Day, Year _____ | 20d. INJURY OCCURRED WHILE AT WORK <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. I attended the deceased from Coroner's Case to her and last saw him alive on _____
Death occurred at 12:01 A.M. 11-24-60 on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | | |
|---|------------------------------|--|--|-------------------------------------|
| 22a. SIGNATURE (In green or blue) <u>Richard E Johnson, M.D.</u> | | 22b. ADDRESS <u>Columbia, Mo.</u> | | 22c. DATE SIGNED <u>11-25-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u> | 23b. DATE <u>11/27/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>C. Albany</u> | 23d. LOCATION (City, town, or county), (State) <u>Columbia, Mo.</u> | |
| 24. FUNERAL DIRECTOR <u>Mrs Stuart Gorker, Columbia, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>Nov. 26 1960</u> | 26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u> | |

DOCUMENT

MEDICAL CERTIFICATION

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 _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George D. Vramm

Licensed Embalmer No. 4425

P. O. Address Columbia

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