

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-048403

ED VS JAN 3 1961

STATE FILE NUMBER

Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 226

1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Marshall</u>		Length of stay in 1b <u>11</u> years		c. CITY OR TOWN <u>Marshall</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Fitzgibbon hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rural route No. 2</u>			Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>6-17-1918</u>	9. AGE (last birthday) <u>42</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (City and state or country) <u>Sedalia Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ray Logan</u>			13b. MOTHER'S MAIDEN NAME <u>Ida J. Danuser</u>			14. NAME OF HUSBAND OR WIFE <u>Thomas L. 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>491-07-4213</u>		17. INFORMANT <u>Rural route</u> Address No. <u>2</u> <u>Thomas L. Butler, Marshall Missouri</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, uterine tube</u>						INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)						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 <u>Marshall Saline Mo.</u>			
20g. COUNTY <u>Saline</u>		20h. STATE <u>Mo.</u>					
21. I attended the deceased from <u>11-5-1960</u> to <u>12-23-1960</u> and last saw her alive on <u>12-23-1960</u> Death occurred at <u>9 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>R. F. Butler M.D.</u> (Deceased or title)				22b. ADDRESS <u>Marshall Mo</u>		22c. DATE SIGNED <u>12-24-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-26-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ridge Park cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Marshall Missouri</u>		
24. FUNERAL DIRECTOR <u>Campbell-Lewis, Marshall Mo.</u> ADDRESS			25. DATE RECD. BY LOCAL REG. <u>12-26-'60</u>		26. REGISTRAR'S SIGNATURE <u>Carol A. Reed</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS JAN 4 1961

OCT 3 0 1961

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

AW Campbell Jr

Licensed Embalmer No. 3469

P. O. Address Marshall

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.