

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-036681

STATE FILE NUMBER

AMENDED

FILED OCT 16 1961

Primary Registration District No. 3023 Registrar's No. 225

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Henry		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Clair	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clinton		Length of stay in lb 1 year	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Clinton Con: Home		d. STREET ADDRESS (If outside, give location) Osceola	
3. NAME OF DECEASED (Type or print) Robert I. Butcher		4. DATE OF DEATH Oct; 12, 1961	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/30/67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant (Retired)		11. BIRTHPLACE (City and state or country) Hickory County Mo; USA	
13a. FATHER'S NAME Marion Butcher		14. NAME OF HUSBAND OR WIFE Marion Butcher, Osceola Mo.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Rectum Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None		PART III. If deceased was female was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input checked="" 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 10/5/60 to 10/12/61 and last saw him alive on 10/10/61 Death occurred at 9:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) S. B. Hughes, M.D.		22b. ADDRESS Clinton Mo.	
22c. DATE SIGNED 10/13/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/16/61	23c. NAME OF CEMETERY OR CREMATORY Holsapple	23d. LOCATION (City, town, or county) (State) Collins Missouri
24. FUNERAL DIRECTOR Goodrich Funeral Home, Osceola Mo.		25. DATE RECD. BY LOCAL REG. Oct 14, 1961	
		26. REGISTRAR'S SIGNATURE Mildred Bigum	

(Licensed Embalmer's Statement on Reverse Side)

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 JB Sanderson

Licensed Embalmer No. 3038

P. O. Address Osceola

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.