

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

15044

1. PLACE OF DEATH

County Jasper Registration District No. 408
 Township Primary Registration District No. 3020
 City Carthage (No. Carthage Hospital) St. Ward)

2. FULL NAME

(a) Residence. No. Golden City Mo. R.I. #1 Ward.
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 4. COLOR OR RACE 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Female White Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Condo G. Butler

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-6-1892

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
36 8 4 — — —

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housewife
 (b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (CITY OR TOWN) Barton Co. Mo.
 (STATE OR COUNTRY)

10. NAME OF FATHER John W. Patterson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Iowa
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Victoria Bottom

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ky.
 (STATE OR COUNTRY)

14. INFORMANT Condo G. Butler
 (Address) Golden City Mo R.I. #1

15. FILED 4/14/29 C. W. Ketchum
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr. 11 19 29

17. I HEREBY CERTIFY, That I attended deceased from 4-2- 1929, to 4-11- 1929
 that I last saw her alive on 4-11- 1929, and that death occurred, on the date stated above, at 2:15 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Surgical Shock following Operation (Hysterectomy)
5/1/29

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Heart Weakness

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH,

19. DID AN OPERATION PRECEDE DEATH? DATE OF

20. WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) David J. ..., M. D.
 , 19 (Address) Carthage, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

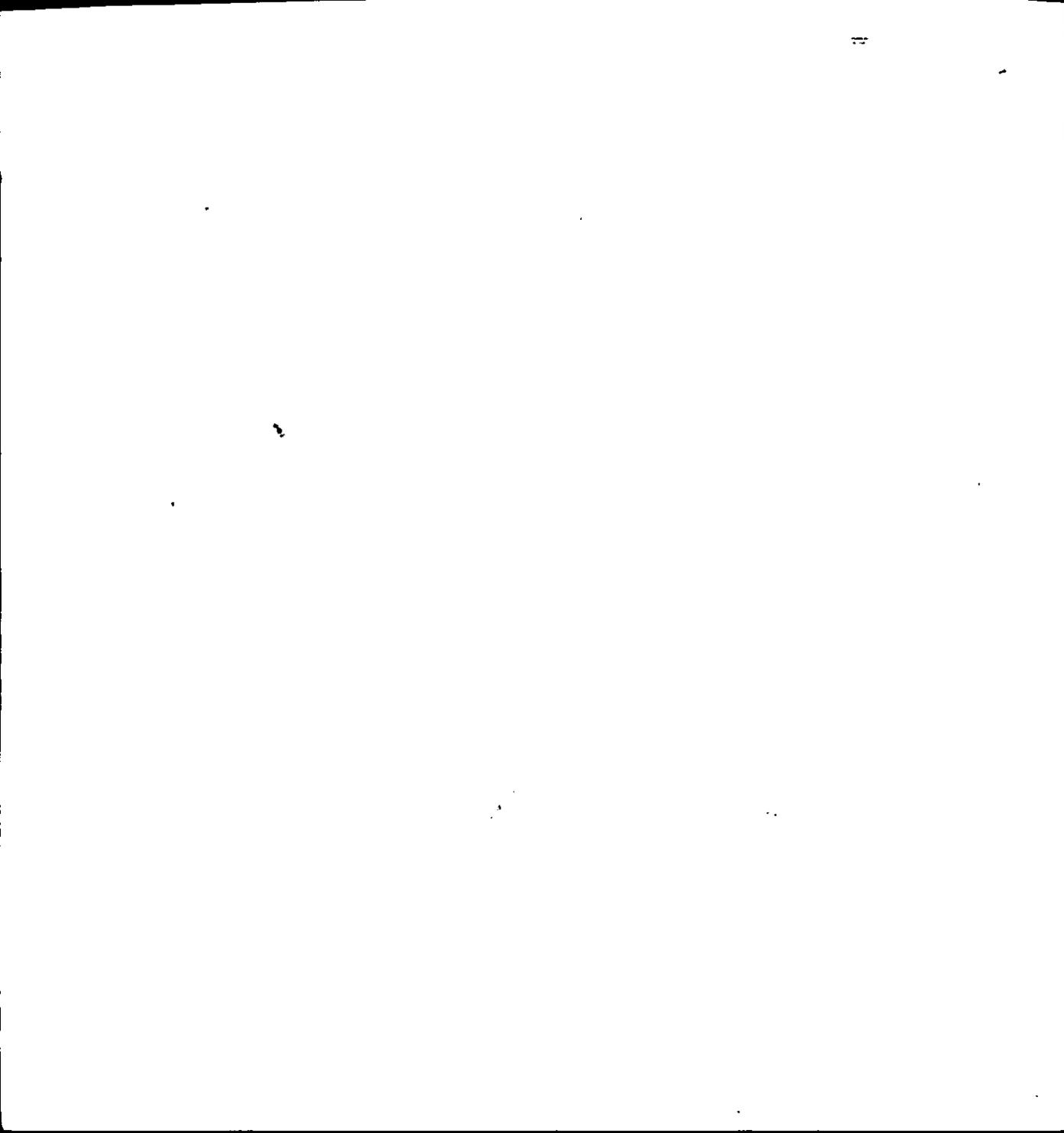
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Franklin Cemetery DATE OF BURIAL 4-13 19 29

20. UNDERTAKER Wm. ... ADDRESS Carthage

PARENTS

APR 27 1929

49
2



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jasper Registration District No. 408 File No. _____
 Township _____ Primary Registration District No. 3020 Registered No. _____
 City Carthage (No. _____) St. _____ Ward _____

2. FULL NAME

Clara Bell Butler

(a) Residence. No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____
 12. MAIDEN NAME OF MOTHER _____
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14. INFORMANT _____
 (Address) _____

15. FILED 6/10 1929 cupkotcham REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 11 1929

17. I HEREBY CERTIFY that I attended deceased from _____ 19____ to _____ 19____ that I last saw h. _____ alive on _____ 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Surgical shock following operation. The malignant fibrosarcoma hysterectomy
 _____ (duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Heart weakness
 _____ (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19 _____ (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-15004

10/10/10