

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

Do not use this space

27053

**1. PLACE OF DEATH**

County Buchanan Registration District No. 85  
 Township \_\_\_\_\_ Primary Registration District No. 1001  
 City St. Joseph Mo. (No. Sisters Hospital)

File No. \_\_\_\_\_  
 Registered No. 1015  
 St. \_\_\_\_\_ Ward) \_\_\_\_\_

**2. FULL NAME**

John Henry Butthman  
 (a) Residence. No. 2209 South 12th St., \_\_\_\_\_ Ward.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) December 2 1893

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
35 8 25

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work. Switchman  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) St. Joseph Missouri  
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry Butthman

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

12. MAIDEN NAME OF MOTHER Mary Ducate

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

14. INFORMANT Joseph Butthman  
 (Address) 2209 South 12th

15. FILED 7 1929 John G. [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) August 27 1929

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 - 29, 1929, to Aug 27, 1929, that I last saw him alive on Aug 27, 1929, and that death occurred, on the date stated above, at 5:45 a. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hemorrhage to death  
Burlington Ry Yards  
 (duration) yrs. mos. ds. 5 hours

CONTRIBUTORY (SECONDARY) Traumatic (R.R. Train)  
dislocation both legs, crush of chest  
 (duration) yrs. mos. ds. 5 hrs

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_  
accidental

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Physical exam  
 (Signed) H.K. Walker, M. D.  
8/28, 1929 (Address) 301 N St Joseph Ave

\*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 Mt. Auburn DATE OF BURIAL Aug 29, 1929

20. UNDERTAKER Fileman Funeral Home ADDRESS 1946 Colham

(From State Board of Health)

Was an automobile involved in this case? If so, where did accident occur, in what county and city or town? Please sign and return.

L. H. J. Wallace  
Automobile not involved  
H. Wallace

**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Duchanan Registration District No. 85- File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 1001 Registered No. 1013  
 City St. Joseph (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M (*write the word*)

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 \_\_\_\_\_, 19\_\_\_\_ REGISTRAR \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 27 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:**

Hemorrhage & Shock -  
Burlington Ky yard

(duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 CONTRIBUTORY (SECONDARY) traumatic (R. R. train) crush of chest  
amputation of both legs (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
accidental

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_

IF NOT AT PLACE OF DEATH \_\_\_\_\_

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

1880

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