

NOV 17 1937

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

Do not use this space.

37664

1. PLACE OF DEATH

County Green
Township
City Springfield Mo. (No. Beege Hospital)

Registration District No. 318
Primary Registration District No. 2001

File No. _____
Registered No. 978 St. _____ Ward)

2. FULL NAME

(a) Residence, No. _____ St. _____ Ward. Grove Springs Mo.
(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

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-8-1937

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

22. I HEREBY CERTIFY, That I attended deceased from 10-4-1937 to 10-8-37, 19____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 3 1937

I last saw him alive on 10-8-37, 19____ Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 0 4 5

to have occurred on the date stated above, at 9:17 m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. child
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Dysentery

Date of onset

10-1-37

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grove Springs Mo.

Other contributory causes of importance:

Aerby dremor 10-4
1 Toxic Encephalitis 10-4
non epidemic

13. NAME Marion G. Buttram

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grove Springs Mo.

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

15. MAIDEN NAME Bessie Climer

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Grove Springs Mo.

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT H G Buttram
(ADDRESS) Grove Springs Mo.

Manner of injury _____
Nature of injury _____

18. BURIAL, CREMATION, OR REMOVAL PLACE Grove Springs Mo. Oct 9, 1937

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

19. UNDERTAKER F. Amley
(ADDRESS) Grove Springs Mo.

(Signed) Arthur Beresford, M. D.

20. FILED Oct 8 37 Chas. A. George Registrar

(Address) Springfield, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

13c

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

37664
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1. PLACE OF DEATH

(a) County Greene Registration District No. 318
 (b) Township _____ Primary Registration District No. 2001 Registered No. 978
 (c) City Springfield (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Urban Buttram

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Child
(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.
4 5

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10 - 8 1932

22. I HEREBY CERTIFY, That I attended deceased from 19____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Toxic Encephalitic
(non epidemic)

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____
 (Signed) Urban Buttram, M. D.
 (Address) Springfield Mo

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

