

REC'D APR 17 1939

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

9627
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township 1st Primary Registration District No. 1002
 (c) City W.E. Mo (d) Street No. 19 E. Van Kleept Registered No. 1233
 (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

(a) Residence, No. 346 Frank J. Butler St. (Usual place of abode, if no street address, write county or city)
2923 Walnut (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sue Butler
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan - 10 - 1887
 7. AGE YEARS 52. MONTHS 2 DAYS 9 If LESS than 1 day,hrs. ormin.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Book Dept
 9. Industry or business in which work was done, as saw mill, bank, etc. Worship Park Gun
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-19-39
 22. I HEREBY CERTIFY, That I attended deceased from 3-10-39, 19..... to 3-19-39, 19.....
 I last saw him alive on 3-19-39, 19..... Death is said to have occurred on the date stated above, at 9:15 a.m.
 The principal cause of death and related causes of importance were as follows:

Myocardial infarction Date of onset
117B
 Other contributory causes of importance:
Post operative Bronchopneumonia

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

FATHER 13. NAME James Butler

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

MOTHER 15. MAIDEN NAME Mar. Stanley

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

17. INFORMANT (ADDRESS) Records Clerk 19 E. Van Kleept

18. BURIAL, CREMATION, OR REMOVAL PLACE St. Marys DATE 3-21-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. H. Blackman 2825 Lindbergh

20. FILED Mar 31 1939 M. M. Crowe Local Registrar.

Name of operation..... Date of 3-18-39
 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) R. H. De Maria, M. D.
 (Address) 5472 Genitor Park

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.