

APR 13 1939

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

11811
Do not use this space.

1. PLACE OF DEATH

(a) County Deming Registration District No. 653
(b) Township Oregon Primary Registration District No. 3866
(c) City _____ (d) Street No. _____
(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.

Registered No. 22

2. PRINT FULL NAME

Delitha Elizabeth Butts

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

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

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

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 15, 1939

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

22. I HEREBY CERTIFY, That Delitha Elizabeth Butts attended deceased from Jan. 15, 1937 to 3/15, 1939
I last saw her alive on Sept. 19, 1938 Death is said to have occurred on the date stated above, at _____ m.

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 2, 1853

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

7. AGE YEARS 87 MONTHS 8 DAYS 13 If LESS than 1 day, _____ hrs. or _____ min.

Arterio-Sclerosis Date of onset _____

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 _____

Other contributory causes of importance: Advanced age

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

Name of operation _____ Date of _____

13. NAME Unknown

What test confirmed diagnosis? clinical Was there an autopsy? no

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

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)

15. MAIDEN NAME Unknown

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

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

Manner of injury _____
Nature of injury _____

17. INFORMANT M. J. Travis (ADDRESS) Nashville, Mo

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____
(Signed) Dr. J. P. ... M. D.
(Address) Caruthersville, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Caruthersville, Mo. DATE Mar. 16, 1939

19. FUNERAL DIRECTOR (NAME) Friends (ADDRESS) _____

20. FILED 3-16-39 JWRhodes Local Registrar.

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

RECEIVED

District Health Officer No. _____

District File Number 39-27

Date Filed 4-11-30

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.