G 19 1939

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
REC'D SEP 7 1939

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30157

Registration District No. 784 | Primary Registration District No. 200 | Registrar's No. 1482

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

1. PLACE OF DEATH:

(a) County St Louis 2

(b) City or town Des Peres Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: R.R.#13 Box 992
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis 1

(c) City or town Des Peres
(If outside city or town limits, write "RURAL")

(d) Street No. R.R.#13 Box 992
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME James Butler 346

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive Deceased

7. Birth date of deceased April (Month) 27 (Day) 1864 (Year)

8. AGE: Years 75 | Months 3 | Days 20 | If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Farmer 0

11. Industry or business 5

FATHER
12. Name Michael Butler
13. Birthplace _____ (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name Kathrine Cooner
15. Birthplace _____ (City, town, or county) Ireland (State or foreign country)

16. (a) Informant's own signature Kathrine Butler
(b) Address Kirkwood R.F.D.B. 992

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-39 (Month) (Day) (Year)
(c) Place: burial or cremation St Josephs Cemetery

18. (a) Signature of funeral director Louis H Boyd
(b) Address 131 W Argonne Dr Kirkwood Mo

19. (a) AUG 19 1939 (Date received local registrar) (b) R.R. Meyer M.D. Dr. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 17 year 1939 hour 4 minute P M.

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__; that I last saw h_____ alive on _____, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Struck by automobile while a pedestrian on a public highway	8/17/39
Due to Fracture of the Skull	8/17/39
Due to	
Other conditions 210 m (Include pregnancy within 3 months of death)	
Major findings: Of operations 21	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence August 17, 1939

(c) Where did injury occur? Des Peres (City or town) Mo (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Place (Specify type of place)

While at work? No (e) Means of injury Struck by auto

23. Signature John O'Connell (M. D. or other)

Address Coroner St Louis County Mo Date signed 8/1

(Licensed Embalmer's Statement on Reverse Side)

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 Louis H Bopp, Registered Apprentice No. ..... working under my personal supervision.

Signed Louis H Bopp

Licensed Embalmer No. 921

P. O. Address Kirkwood

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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