

1. PLACE OF DEATH

(a) County BATES  
(b) City or town BUTLER  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 80 YRS  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County BATES  
(c) City or town BUTLER  
(d) Street No.....  
(e) Citizen of foreign country?.....  
If yes, name country.....

3. (a) PRINT FULL NAME EDWIN S. DANIEL

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 3

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

7. Birth date of deceased OCT 28 1842  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
90 3 28 hr. min.

9. Birthplace PETTIS CO Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation JANITOR - (RETIRED)

11. Industry or business SCHOOL - EAST

MOTHER FATHER { 12. Name ALFRED DANIEL  
13. Birthplace N. CAROLINA  
14. Maiden name UNKNOWN  
15. Birthplace "

16. (a) Informant Clem Daniel  
(b) Address Richfield, Kansas

17. (a) BURIAL (b) Date thereof 3-1-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MORRIS CEM

18. (a) Signature of funeral director BOOTH  
(b) Address BUTLER MO

19. (a) 2/28/42 (b) Mrs. L. Evelyn  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month FEB day 26  
year 1942 hour 2 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 19 30 to Feb 26 42  
that I last saw him alive on Feb 26, 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary atherosclerosis

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

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

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?.....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... Means of injury 0

23. Signature [Signature] (M. D. or other) 3/1/42  
Address Butler, Mo Date signed 3/1/42

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

RECEIVED

District Health Officer No. 7,

District File Number 3-42-213

Date Filed 3-10-42

---

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.....

*John H. Anderson*

Licensed Embalmer No. 3585

P. O. Address. Butler Pa

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, fact should be so stated above.

2B  
41  
29288

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 5811

Registration District No. 50

Primary Registration District No. 3004

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Bates

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

(c) Name of hospital or institution: \_\_\_\_\_  
(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 \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Edwin S Daniel

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day \_\_\_\_\_ year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

4. Sex m 5. Color or race w

6. (a) Single, widowed, married, divorced ce

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 28 1885  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>96</u>	<u>3</u>	<u>20</u>	hr _____ min. _____

Due to Carcinoma gastric  
adenoma of stomach

Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

46 b

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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

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

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of plate) \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Edw S Daniel (M. D. or other) \_\_\_\_\_  
Address Butler Mo Date signed 2/26/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-5811