

FILED APR 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7344

BIRTH NO. _____		REG. DIST. NO. <u>27</u>		PRIMARY REG. DIST. NO. <u>3000</u>		Registrar's No. <u>40</u>	
1. PLACE OF DEATH a. COUNTY <u>Rates</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Rates</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Butler</u>		c. LENGTH OF STAY (In this place) <u>24 Hrs.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Butler</u>		d. STREET ADDRESS (If rural, give location) <u>Rural-Shawneeek Twp.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Butler Memorial Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>Rural-Shawneeek Twp.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>Lee</u> c. (Last) <u>Atkins</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 8 1949</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 19, 1892</u>		9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Vian Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Joseph Atkins</u>		13b. MOTHER'S MAIDEN NAME <u>Craig</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Jane Atkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Sarah Jane Atkins</u> <u>Butler Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Hypertension, Cystitis, both kidneys</u> ANTECEDENT CAUSES <u>Unknown</u> DUE TO (b) <u>Unknown</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Uremia</u> <u>1005'</u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>	
19a. DATE OF OPERATION <u></u>		19b. MAJOR FINDINGS OF OPERATION <u>none between Hosp</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u></u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Butler Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u></u>		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>April 7</u> , 1949, to <u>April 8</u> , 1949, that I last saw the deceased alive on <u>April 8</u> , 1949, and that death occurred at <u>10 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. E. Robinson M.D.</u>				23b. ADDRESS <u>Butler Mo</u>		23c. DATE SIGNED <u>4-9-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr. 10, 49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		24d. LOCATION (City, town, or county) (State) <u>Butler Mo</u>		
DATE REC'D BY LOCAL REG. <u>Apr. 9-49</u>		REGISTRAR'S SIGNATURE <u>Nedell Kuryou</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leath &amp; Son</u> <u>Adrian Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

JUN 1 1949

JUN 2 1949

APR 10 1949

MAY 2 1949

RECEIVED  
District Health Officer No. 7,  
District File Number 5-49-344  
Date Filed 4-11-49

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed..... *Leblond*

Signed.....  
Student Embalmer

Licensed Embalmer No. 3650

P. O. Address Adrian Mo

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.