

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 15 1950

State File No. **28063**
Registrar's No. **7508**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (In this place) Unknown	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION. Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2826 Dickson St.	

3. NAME OF DECEASED (Type or Print) Florence	a. (First)	b. (Middle)	c. (Last) Buttner	4. DATE OF DEATH (Month) (Day) (Year) August 30 1950
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 6, 1907	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months 5 Days 24	IF UNDER 6 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Glasgow, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Witty Cason	13b. MOTHER'S MAIDEN NAME Maud Brownson	14. NAME OF HUSBAND OR WIFE Clarence Buttner
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Clarence Buttner	ADDRESS 2826 Dickson
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 3 mos 2 years
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension		
	DUE TO (c) Undetermined		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 331X
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22. I hereby certify that I attended the deceased from **8-28**, 19**50**, to **8-30**, 19**50**, that I last saw the deceased alive on **8-30**, 19**50**, and that death occurred at **10:50a** m., from the causes and on the date stated above.

23a. SIGNATURE Loreiso Harris (Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 8-31-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE SEP 4 1950	24c. NAME OF CEMETERY OR CREMATORY Glasgow, Mo. Cem.	24d. LOCATION (City, town, or county) (State) Glasgow Mo.
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DATE REC'D BY LOCAL REG. SEP 4 1950	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Russell Und. Co.	ADDRESS 2732 Pine St.
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Clark Young*

Licensed Embalmer No. *3371*

P. O. Address *St. Louis*

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.