

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **14111**
3635
Registrar's No.

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 3635	
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) 3-mon.	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2177
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			d. STREET ADDRESS (If rural, give location) 19 4360 Olive Street.		
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle)	c. (Last) Buttermore	4. DATE OF DEATH (Month) (Day) (Year) 4-16-1952	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S. (1)	8. DATE OF BIRTH Feb. 24, 1870	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months 1 Days 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Michael Buttermore		13b. MOTHER'S MAIDEN NAME Mary Seaward		14. NAME OF HUSBAND OR WIFE	
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 ADDRESS Mrs. Emil C. Fischer, 4460 N. 70th. St.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, Rt. colon			INTERVAL BETWEEN ONSET AND DEATH ? 2 yrs.
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION 2-5-52		19b. MAJOR FINDINGS OF OPERATION Inoperable Carcinoma Rt. colon		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)		
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? 153X		
22. I hereby certify that I attended the deceased from 1-25 , 19 52 , to 2-20 , 19 52 , that I last saw the deceased alive on 2-20 , 19 52 , and that death occurred at 1:40 a.m. , from the causes and on the date stated above.					
23a. SIGNATURE Thomas J. Weiler, M.D.		(Degree or title)	23b. ADDRESS 6347 N. Grand	23c. DATE SIGNED 4-16-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Apr. 19, 1952	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL REG. APR 17 1952		REGISTRAR'S SIGNATURE J. C. Smith	25. FUNERAL DIRECTOR'S SIGNATURE Walter J. Donnelly	ADDRESS 3840 Lindell Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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

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 me

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed [Signature]

Licensed Embalmer No. 4199

P. O. Address St. Charles, 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.