Health, Welfare Public Service

FILED JAN 30 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2734

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 839

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN ST. LOUIS 2500 S. 18th St. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) LITTLE FLOWER NURSING HOME — Length of stay in 1b 37	d. STREET ADDRESS (If outside, give location) 2310 18th & VICTOR ST — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First JAMES Middle BUTLER Last		4. DATE OF DEATH Month JAN. Day 22 Year 1958	
5. SEX MAle	6. COLOR OR RACE WHITE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	8. DATE OF BIRTH JULY 14 1871
9. AGE (In years last Monday) 86	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRAIN DISPATCHER	10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	11. BIRTHPLACE (City and state or country) UNKNOWN	12. CITIZEN OF WHAT COUNTRY? UNKNOWN
13a. FATHER'S NAME JAMES BUTLER	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF ~~HUSBAND~~ OR WIFE CECELIA BUTLER DEC'D	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT CARL BARTELSON Address 7036 KINGSBURY	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute R. Lower Lobar Pneumonia	Jan 20 1958
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic myocarditis	6 mo
DUE TO (c)	Generalized arteriosclerosis	10 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 422.1

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Aug 1 58, to Jan 22 1958 and last saw her/him alive on Jan 22 1958

Death occurred at 11:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Tupper Plumpe	22b. ADDRESS 3933 S Grand	22c. DATE SIGNED Jan 23/58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 1-23-58	23c. NAME OF CEMETERY OR CREMATORY ROSELAWN MEM. PARK
23d. LOCATION (City, town, or county) TERRE HAUTE (State) IND.		
24. FUNERAL DIRECTOR Thomas Kutis ADDRESS 2906 Gravois	25. DATE RECD. BY LOCAL REG. JAN 23 '58	26. REGISTRAR'S SIGNATURE J Carl Smith MD M&B

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard ... All diseases in Part I must be causally related.

FR 3-4000

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.

Student ..... Signature of Student Embalmer

Signed Sumner C Dill

Licensed Embalmer No. 4347

P. O. Address 2906 Stavan

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.