

Health,
& Welfare
Public
Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029911

STATE FILE NUMBER

FILED AUG 26 1958

Registration District No. 278

Primary Registration District No. 3054

Registrar's No. 122

1. PLACE OF DEATH a. COUNTY PIKE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY PIKE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN LOUISIANA		c. CITY OR TOWN LOUISIANA	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION PIKE Co. HOSPITAL		d. STREET ADDRESS (If outside, give location) 1310 GEORGIA ST.	
3. NAME OF DECEASED (Type or print) First ANNIE Middle LAURA Last BUTTS		4. DATE OF DEATH Month Aug. Day 14 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 4, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSE KEEPING	11. BIRTHPLACE (City and state or country) PIKE Co., Mo.
13a. FATHER'S NAME JOHN B. CARROLL		13b. MOTHER'S MAIDEN NAME MILDRED VARNON	14. NAME OF HUSBAND OR WIFE JOE BUTTS
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. NONE	17. INFORMANT JOHN CARROLL, RFD, LOUISIANA, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart disease DUE TO (b) General Arterio Sclerosis DUE TO (c) 4202 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH but not related to the terminal disease condition given in PART I (a) Severe Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>	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 8/02/58 through 8/14/58 and last saw her alive on 8/14/58 Death occurred at 1:35 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Robert L. Anderson M.D.		22b. ADDRESS Louisiana, Mo.	22c. DATE SIGNED 8/16/58
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 8/17/58	23c. NAME OF CEMETERY OR CREMATORY FRANKFORD CEMETERY	23d. LOCATION (City, town, or county) (State) FRANKFORD, MO.
24. FUNERAL DIRECTOR STERNE FUNERAL HOME, LOUISIANA, MO.		25. DATE RECD. BY LOCAL REG. Aug 19-1958	26. REGISTRAR'S SIGNATURE Bernice Collier

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

YS MAY 4 1960

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 *Virginia Stearns Esterbrook*

Licensed Embalmer No. *4645*

P. O. Address *Louisiana, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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