

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-020060

STATE FILE NUMBER

FILED JUN 15 1959 Registration District No. 324 Primary Registration District No. 3072 Registrar's No. 94

1. PLACE OF DEATH a. COUNTY <b>Saline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Marshall</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Marshall</b> <b>09720</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>553 West Marion</b>		Length of stay in 1b <b>45 years</b>	d. STREET ADDRESS (If outside, give location) <b>553 West Marion</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Elizabeth Butts Schrand</b>			4. DATE OF DEATH Month Day Year <b>June 11th 1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1892</b>
9. AGE (In years last birthday) <b>67</b>		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) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (City and state or country) <b>Cooper County, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>James William Butts</b>	
13b. MOTHER'S MAIDEN NAME <b>Nannie Berry</b>		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) <b>No</b>		16. SOCIAL SECURITY NO. <b>500-10-9203</b>	17. INFORMANT <b>George Schrand</b> Address <b>Raytown, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Arteriosclerotic Heart Disease</b>			UNKNOW
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Bronchopneumonia (Viral)</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT 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 <b>20 Feb, 1919</b> to <b>June 11, 1959</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>June 11, 1959</b> Death occurred at <b>9-15 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Robert W. DeLoach M.D.</b>		22b. ADDRESS <b>370 S Odell, Marshall, Missouri</b>	22c. DATE SIGNED <b>6-12-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>June 13, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ridge Park cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Marshall Missouri</b>
24. FUNERAL DIRECTOR ADDRESS <b>Cambell-Lewis, Marshall, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>6-12-59</b>	26. REGISTRAR'S SIGNATURE <b>Cecil G. Read</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 8 7 1956

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 *James A. Lewis* .....

Licensed Embalmer No. *4709* .....  
P. O. Address *Marshall* .....

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.