

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024436

FILED VS JUL 24 1959

Registration District No. 29 Primary Registration District No. 4097 Registrar's No. 127

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Cass</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Harrisonville</u> b. COUNTY <u>Cass</u>											
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Harrisonville</u>		Length of stay in 1b <u>9 mo.</u>		c. CITY OR TOWN <u>Harrisonville</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1101 N Lexington</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1101 N. Lexington</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLIE MAE BUTLER</u>				4. DATE OF DEATH Month Day Year <u>July 11 1959</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 20 1874</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Harrisonville Ark.</u>				11. BIRTHPLACE (City and state or country) <u>Harrisonville Ark.</u>				12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>W.B. Montgomery</u>				13b. MOTHER'S MAIDEN NAME <u>Narcissa E. McCholland</u>				14. NAME OF HUSBAND OR WIFE <u>Will H. Butler</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>J. L. Fowler Sr. Harrisonville Mo</u>				Address <u>01 20 Lexington Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u>					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b)					
										DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>MAL NUTRITION</u>										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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. <u>✓</u>		Month, Day, Year <u>✓</u>													
20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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 <u>July 1954</u> to <u>July 11/59</u> and last saw her alive on <u>July 11/59</u> Death occurred at <u>1101 N Lexington</u> on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE (Degree or title) <u>D. J. Sargent M.D.</u>						22b. ADDRESS <u>Harrisonville Mo</u>			22c. DATE SIGNED <u>12/14/59</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 12 1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>White Rose Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Harrisonville Okla.</u>							
24. FUNERAL DIRECTOR <u>Wannenburg Harrisville</u>				ADDRESS <u>Harrisville</u>		25. DATE RECD. BY LOCAL REG. <u>7-12-59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Gay Sebee</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James R. Phillips

Licensed Embalmer No. 4641

P. O. Address Harrisonville

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.