

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 27 1959

59-027920

Registration District No. 359 Primary Registration District No. 279600 Registrar's No. 6222

STATE FILE NUMBER

|   |  |   |  |   |   |  |   |  |
|---|--|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Vernon</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Vernon</b> |   |  |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Moundville</b>   |  | Length of stay in 1b  |  | c. CITY OR TOWN <b>Moundville</b>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   |   |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Highway 43, 1 1/2 Mi. North</b>  |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   | d. STREET ADDRESS (If outside, give location) <b>General delivery</b>   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>Moundville</b> First <b>Minnie</b> Middle <b>P.</b> Last <b>Butler</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>15</b> Year <b>1959</b>  |   |  |   |  |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>wh</b>   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>June 16, 1886</b>   | 9. AGE (last birthday) <b>73</b>  | IF UNDER 1 YEAR<br>Months  | IF UNDER 24 HR<br>Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country) <b>Henry County Missouri</b> |  | 12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>   |  |
| 13a. FATHER'S NAME <b>John M. Colson</b>  |  |   | 13b. MOTHER'S MAIDEN NAME <b>Sarah Rebecca Cragg</b>   |   |   | 14. NAME OF HUSBAND OR WIFE <b>William S. Butler, deceased</b>   |   |  |
| 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>none</b>  |   | 17. INFORMANT Address <b>George Fisher, Rt. 2, Nevada, Missouri</b>     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Basal Skull Fracture</b>   |  |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH <b>3-5 min</b>                                       |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____  |  |   |  |   |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)   |  |   |  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input checked="" 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.) <b>Gasoline truck + auto accident</b> |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Hour <b>1:00 pm</b> Month, Day, Year <b>7-15-59</b>  |  | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>43 Highway</b>                                |   | 20f. CITY, TOWN, OR LOCATION <b>VERNON</b> COUNTY <b>MO.</b> STATE <b>MO.</b>  |   |  |
| 21. I attended the deceased from _____ to _____ and last saw her/him alive on _____<br>Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |  |   |   |  |   |  |
| 22a. SIGNATURE <b>Richard Minter</b> (Degree or title) <b>Coroner</b>   |  |   |  | 22b. ADDRESS <b>Nevada, MO</b>  |   |  | 22c. DATE SIGNED <b>7-18-59</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |  | 23b. DATE <b>7-18-1959</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Newton Burial Park</b>   |   | 23d. LOCATION (City, town, or county) <b>Nevada, Missouri</b> (State)   |  |   |  |
| 24. FUNERAL DIRECTOR <b>Ferry Funeral Home Nevada, Missouri</b> ADDRESS   |  |   |  | 25. DATE RECD. BY LOCAL REG. <b>July 23 - 1959</b>  |   | 26. REGISTRAR'S SIGNATURE <b>Mrs. Ruth Faith</b>   |   |  |

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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 *L. August Ferry*

Licensed Embalmer No. 4960

P. O. Address Nevada

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.