

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-009478**

**FILED VS MAR 3 1960 333**

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 50

STATE FILE NUMBER

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Scott</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hospital</u> Inside Limits <input type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before registration) a. STATE <u>Mo</u> b. COUNTY <u>New Madrid</u> c. CITY OR TOWN <u>Marionville</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) _____ Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CALLIE</u> Middle <u>ANN</u> Last <u>BUTLER</u>			<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>10</u> Year <u>1960</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-11-1902</u>	<b>9. AGE (last birthday)</b> <u>57</u>	<b>IF UNDER 1 YEAR</b> Months <u>1</u> Days <u>29</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (City and state or country) <u>Seneth, Mo.</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U. S. A.</u>		
<b>13a. FATHER'S NAME</b> <u>Billie Williams</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Cornelia Hays</u>		<b>14. NAME OF HUSBAND OR WIFE</b> <u>Zelmer Butler</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____		<b>16. SOCIAL SECURITY NO.</b> _____		<b>17. INFORMANT</b> <u>Beilie Butler - Sikeston, Mo.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Hypertensive Cerebrovascular</u> DUE TO (c) <u>Diabetes Mellitus, Senes</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>29 days</u> yes <input checked="" type="checkbox"/> no <input type="checkbox"/>		
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. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____					
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____			
<b>21. I attended the deceased from</b> <u>8:5 AM</u> <u>1-27-60</u> to <u>11/60</u> and last saw her <u>alive</u> on <u>11/60</u> Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <u>Stephen Perry M.D.</u>			<b>22b. ADDRESS</b> <u>Bloomfield, Mo</u>		<b>22c. DATE SIGNED</b> <u>2-20-60</u>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE</b> <u>1/13/1960</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Garden of Memories</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>Sikeston, Mo</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Whitton Funeral Home</u> <b>ADDRESS</b> <u>Sikeston, Mo</u>		<b>25. DATE RECD. BY LOCAL REG.</b> <u>2-23-60</u>		<b>26. REGISTRAR'S SIGNATURE</b> <u>Miss Ella Hunter</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 Raymond L. Duggan

Licensed Embalmer No. 4798

P. O. Address Bernie M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.