

FURTHER DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 10 1960

318

Primary Registration District No. 1003

Registrar's No.

10665-60-039595
STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 5215a Thekla		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First EUGENE Middle C. Last BUTLER				4. DATE OF DEATH Month NOVEMBER Day 3 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 7-6-1906	9. AGE (last birthday) 54	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Iowa		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Clyde Butler			13b. MOTHER'S MAIDEN NAME Faye Rathborn			14. NAME OF HUSBAND OR WIFE Gladys Butler			
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. 488-09-1181		17. INFORMANT William E. Butler		Address Pine Lawn, Mo 3739 Manola			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Recurrent glioblastoma								2 yrs.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								DUE TO (b)	
								DUE TO (c) 1939	
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			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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 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 7/18/60 to 11/3/60 and last saw ^{him} live on 11/3/60 Death occurred at 11:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>C. J. Hamilton, M.D.</i> (Degree or title)				22b. ADDRESS BARNES HOSPITAL				22c. DATE SIGNED 11/4/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-4-1960	23c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery			23d. LOCATION (City, town, or county) (State) Farmington, Missouri			
24. FUNERAL DIRECTOR Sparks Funeral Home Flat River, Mo. ADDRESS				25. DATE RECD. BY LOCAL REG. NOV 4 1960		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

0964 C AOM SA

STATE OF MISSISSIPPI

REAR 28 1967

APR 10 1967

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 *Murphy Spauld*

Licensed Embalmer No. *4256*

P. O. Address *Slott River*

STATE OF MISSISSIPPI

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.