

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-014809

STATE FILE NUMBER

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 111

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 18 1963

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Audrain | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Montgomery | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Mexico Length of stay in lb | | c. CITY OR TOWN Wellsville Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Audrain Hospital Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) RR #2 Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |

| | | | | | |
|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last William B Butts | | | 4. DATE OF DEATH Month Day Year April 15, 1963 | | |
|---|--|--|--|--|--|

| | | | | | | |
|--------------------|-------------------------------|---|--------------------------------------|----------------------------------|---|---|
| 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 Aug. 3, 1905 | 9. AGE (last birthday) 54 | IF UNDER 1 YEAR Months 8 Days 12 | IF UNDER 24 HR. 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 Interior decorating | 11. BIRTHPLACE (City and state or country) Elkator, Iowa | 12. CITIZEN OF WHAT COUNTRY USA |
|--|--|---|--|

| | | |
|---|--|---|
| 13a. FATHER'S NAME George W. Butts | 13b. MOTHER'S MAIDEN NAME Lillian Woods | 14. NAME OF HUSBAND OR WIFE Lenora Butts |
|---|--|---|

| | | |
|---|---|---|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of no) | 16. SOCIAL SECURITY NO. [REDACTED] | 17. INFORMANT Address Mrs Lenora Butts, Wellsville, Mo |
|---|---|---|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lung | | INTERVAL BETWEEN ONSET AND DEATH 5mo |
| 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) | 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 type="checkbox"/> NO <input checked="" 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 4-7-63 to 4-15-63 and last saw her/him alive on 4-15-63.
Death occurred at 8:00 m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | |
|--|--------------------------------|---------------------------------|
| 22a. SIGNATURE (Degree or title) Ernest J. Gault M.D. | 22b. ADDRESS Mexico, Mo | 22c. DATE SIGNED 4-16-63 |
|--|--------------------------------|---------------------------------|

| | | | |
|---|---------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE April 18, 1963 | 23c. NAME OF CEMETERY OR CREMATORY New Hampton | 23d. LOCATION (City, town, or county) New Hampton, Iowa |
|---|---------------------------------|---|--|

| | | |
|---|---|--|
| 24. FUNERAL DIRECTOR ADDRESS Howard F. Myers, Wellsville, Mo | 25. DATE RECD. BY LOCAL REG. April 16-1963 | 26. REGISTRAR'S SIGNATURE Blanche Neely |
|---|---|--|

(Licensed Embalmer's Statement on Reverse Side)

VS 300 Rev. 4/59
10047
20700
3
4 0
5 1
6
7 1
8 2
9 163X
10
11
12 1-0
13 2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK

OR

TYPewriter RIBBON
Ernest J. Gault M.D.

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 Howard Myers

Licensed Embalmer No. 4494

P. O. Address Wellsville, Mo.

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.