STATE OF TEXAS 015-00-213008-00 CERTIFICATE OF DEATH 2041 20 STATE FILE NO. 24135

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE	b. County Parish
BEXAR		LOUISIANA	CADDO
b. CITY OR TOWN (If outside city limits, give precinct no.)	c. LENGTH OF STAY in 1 b.	c. CITY OR TOWN (If outside city limits, give precinct no.)	
LACKLAND AFB	26 Days	SHREVEPORT	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS (If rural, give location)	
WILFORD HALL USAF MEDICAL CENTER		3517 REDBUD LANE	
e. IS PLACE OF DEATH INSIDE CITY LIMITS? YES ☐ NO ☒		e. IS RESIDENCE INSIDE CITY LIMITS? YES ☒ NO ☐	f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) (a) First	(b) Middle	(c) Last	4. DATE OF DEATH
ROBERT	PAUL	BUTLER	10 APRIL 1970

5. SEX	6. COLOR OR RACE	7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Minutes
MALE	CAUC	Widowed	30 APRIL 1921	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
AIR FORCE RETIRED	AIR FORCE	OKLAHOMA	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CALVIN A. BUTLER	EDNA E. DICKINSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
YES	unknown	439-12-1280	OFFICIAL HOSPITAL RECORDS

MEDICAL CERTIFICATION

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)	Bronchopneumonia	2-3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Chronic lymphocytic leukemia	3 years
DUE TO (c)		

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office building, etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I hereby certify that I attended the deceased from 7 APRIL 1970 to 10 APRIL 1970 and last saw the deceased alive on 10 APRIL 1970 Death occurred at 205 a m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
W. H. Orrison MD	WILFORD HALL USAF MEDICAL CENTER	10 Apr 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY
Removal for Burial	April 10, 1970	City Cemetery

23d. LOCATION (City, town, or county)	(State)	24. FUNERAL DIRECTOR'S SIGNATURE
Shreveport,	Louisiana	Terrell D. Goddard Porter Loring Mort.

25a. REGISTRAR'S FILE NO.	25b. DATE REC'D BY LOCAL REGISTRAR	25c. REGISTRAR'S SIGNATURE
1977	APR 13 70	R. M. Wanningham

TEXAS DEPARTMENT OF HEALTH — BUREAU OF VITAL STATISTICS

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