

FILED JUN 7 1943

Registration District No. **149**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Jackson City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Wakenick Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **12 da**
(Specify whether years, months or days)

In this community **40 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson 48**

(c) City or town **Raytown Mo.**
(If outside city or town limits, write "RURAL")

(d) Street No. **67th & Wildwood Rd.**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Lonia Leighton Butner**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **Unknown**

4. Sex **Male** 5. Color or race **Whit** 6. (a) Single, widowed, married, divorced, **Widowed**

6. (b) Name of husband or wife **Mrs Bertha Butner** 6. (c) Age of husband or wife if alive **deceased** years

7. Birth date of deceased **Jan 29 1879**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	64	3	8	hr. _____ min. _____

9. Birthplace **Unknown Ky. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER

12. Name **John Butner**

13. Birthplace **Unknown Ky. 1**
(City, town, or county) (State or foreign country)

14. Maiden name **Sarah Butner**

15. Birthplace **Unknown Ky. 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ray Butner**

(b) Address **Raytown Mo.**

17. (a) **Private Burial** (b) Date thereof **May 10 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Wakenick Hospital Raytown Mo.**

18. (a) Signature of funeral director **E. Black Regent**

(b) Address **Raytown Mo.**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **7** year **1943** hour **4** minute **07 P.M.**

21. I hereby certify that I attended the deceased from **April 25** 19**43** to **May 5** 19**43**
that I last saw **in** alive on **May 5** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary occlusion 6 hrs.**

Due to **Ruptured diverticulum 10 hrs.**
of bladder

Due to **Prostatism 3 yrs.**

Other conditions **1370**
(Include pregnancy within 3 months of death)

Major findings: **Prostate Hypertrophy**
or operations **Ruptured Diverticulum**

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **No.**

While at work? _____
(Specify type of place)

(i) Means of injury _____

23. Signature **R. D. Brown** (M. D. or other) **200**

Address **714 Chambers Bldg.** Date signed **5/14/43**

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed

Clark Regent

Licensed Embalmer No.

3983

P. O. Address

Raytown 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 this body is not embalmed, fact should be so stated above.