

FILED SEP 18 1951

BIRTH NO. REG. DIST. NO. 27 PRIMARY REG. DIST. NO. 5096 Registrar's No. 82

1. PLACE OF DEATH a. COUNTY Bates		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Wandotte	
c. LENGTH OF STAY (In this place) Butler		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City Mo. North 8150	
d. FULL NAME OF HOSPITAL OR INSTITUTION Butler Memorial Hospital		d. STREET ADDRESS (If rural, give location) 1505 Southwest Blvd	
3. NAME OF DECEASED a. (First) Charles b. (Middle) Milford c. (Last) Dietrich		4. DATE OF DEATH (Month) (Day) (Year) Sept. 9 1951	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH May 5 1936
9. AGE (In years last birthday) 15		10. MONTHS 4	11. HOURS 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kansas City Kansas		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME John J. Dietrich		13b. MOTHER'S MAIDEN NAME Lola Azalee Burke	
14. NAME OF HUSBAND OR WIFE single		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 515 28 8007		17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Frank L. Hicks 1505 SW Blvd. Kansas City Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) multiple fractures skull DUE TO (c) trauma (automobile accident)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. fractures of ribs and inter- thoracic injuries.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION no	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT (Specify) accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) U.S. Highway 71	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Mound Twp. Bates Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 9 1951 12:45 PM	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR #308 PM

22. I hereby certify that I attended the deceased from **1:30 PM** to **9:30 PM**, that I last saw the deceased alive on **9 Sept**, 1951, and that death occurred at **1:30 PM**, from the causes and on the date stated above.

23a. SIGNATURE Doris Z. Hatcher M.D.	23b. ADDRESS 152 North Bank Butler Mo	23c. DATE SIGNED 9 Sept 1951
24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE Sept 12 1951	24c. NAME OF CEMETERY OR CREMATORY UNKNOWN
24d. LOCATION (City, town, or county) (State) K. C. Mo. Kansas	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Oliver Underwood - Butler Mo.	
DATE REC'D BY LOCAL REG. Sept. 9 1951	REGISTRAR'S SIGNATURE Randall Kroy	

WRITE PAINTLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 9-17-51

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 9-17-51 _____

1305

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JAMES W. BUTLER

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____
Student Embalmer

Signed *John G. Underwood*

Licensed Embalmer No. *3585*

P. O. Address *Butler 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.