

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32472

State File No.

S. No. 300
v. 10. 48

FILED SEP 23 1952

BIRTH NO. _____ REG. DIST. NO. 274 PRIMARY REG. DIST. NO. 3052 Registrar's No. 290

1. PLACE OF DEATH a. COUNTY <u>Pettis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sedalia</u>	
c. LENGTH OF STAY (in this place) <u>16 months</u>		d. STREET ADDRESS (If rural, give location) <u>1713 So. Osage</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1713 So. Osage</u>		e. STREET ADDRESS <u>1713 So. Osage</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) <u>B.</u> c. (Last) <u>Butterbaugh</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 14 1952</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Aug 2 - 1864</u>	9. AGE (In years last birthday) <u>88</u>	10. UNDER 1 YEAR Days <u>1</u> Hours <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>David Butterbaugh</u>		13b. MOTHER'S MAIDEN NAME <u>Priscilla Ward</u>		14. NAME OF HUSBAND OR WIFE <u>Edith Bell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Susan Loucks</u> ADDRESS <u>Sedalia</u>	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>hypertension</u> DUE TO (c) <u>sclerosis & senility</u>			years
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/9, 1952, to 9/14, 1952, that I last saw the deceased alive on 9/14, 1952, and that death occurred at 7:50 p. m., from the causes and on the date stated above.

23a. SIGNATURES (Degree or title) <u>W. McQuinn M.D.</u>		23b. ADDRESS <u>Sedalia, Mo.</u>		23c. DATE SIGNED <u>9/15/52</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-16-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hopewell cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Sedalia Rural Mo</u>	
DATE REC'D BY LOCAL REG. <u>9-16-52</u>		REGISTRAR'S SIGNATURE <u>W. J. Campbell M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs Laughlin Bros</u>		ADDRESS <u>Sedalia</u>	

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

5804
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SEP 30 1952

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
Student Embalmer

Signed _____

K. P. M. Cray

Licensed Embalmer No. _____

3153

P. O. Address _____

Sedalia 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.