

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017637

STATE FILE NUMBER

FILED MAY 29 1959 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2208

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| 1. PLACE OF DEATH a. COUNTY <u>Jackson</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas city mo</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>Kansas City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Huebner's Nursing Home</u> INSTITUTION <u>3215 Campbell</u> | | Length of stay in lb <u>2 yrs</u> | d. STREET ADDRESS (If outside, give location) <u>3215 Campbell</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First <u>Peter</u> Middle <u>F.</u> Last <u>Butler</u> | | | 4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1959</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-23-1870</u> | | 9. AGE (In years last birthday) <u>89</u> IF UNDER 1 YEAR: Months <u>8</u> Days <u>9</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u> | |

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| 10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <u>Retired</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u> | 11. BIRTHPLACE (City and state or country) <u>Boston, Mt Arkansas</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Daniel G Butler</u> | 13b. MOTHER'S MAIDEN NAME <u>Elizabeth Reaser</u> | 14. NAME OF HUSBAND OR WIFE <u>Frances L Butler</u> |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | 16. SOCIAL SECURITY NO. <u>none</u> | 17. INFORMANT <u>Clara B Rhoades</u> Address <u>2300 W 51st St KC Mo</u> |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer - Retum</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> |
| 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) <u>154X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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 _____ o.m. _____ p.m. _____ | | | |
| 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 Dec 1957 to Mar 4, 1959 and last saw him alive on Mar 4 - 59
Death occurred at 11 A m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE (Degree or title) <u>Arthur B Rhoades M.D.</u> | 22b. ADDRESS <u>630 Professor Bldg Kc</u> | 22c. DATE SIGNED <u>5/6/59</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>5-4-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Birch tree Cem.</u> | 23d. LOCATION (City, town, or county) (State) <u>Birch tree Mo</u> |
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| 24. FUNERAL DIRECTOR <u>Duncan Funeral Home</u> <u>mt view, mo</u> | ADDRESS <u>mt view, mo</u> | 25. DATE RECD. BY LOCAL REG. <u>5-4-59</u> | 26. REGISTRAR'S SIGNATURE <u>Neva Minshall</u> |
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(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Arthur B. Rhoades



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 *Russell N. France*

Licensed Embalmer No. *4255*

P. O. Address *KC 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.