

**FURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**59-039948**

**FILED VS DEC 10 1959**

Registration District No. 149 Primary Registration District No. 1001 Registrar's No. 5506 STATE FILE NUMBER

UNRECORDED

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>PLATTE</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY, MO.</b>		Length of stay in 1b <b>11 MONTHS</b>	c. CITY OR TOWN <b>PLATTE CITY</b> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MALOTTE NURSING HOME</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>CARROLL TWNS.</b> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>REUBEN</b> Middle <b>J.</b> Last <b>BUTLER</b>			4. DATE OF DEATH Month <b>NOV.</b> Day <b>15</b> Year <b>1959</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHOTOGRAPHER</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>83</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____
11. BIRTHPLACE (City and state or country) <b>BLOOMINGTON ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>John Butler</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Ward</b>	14. NAME OF HUSBAND OR WIFE <b>BERTHA BUTLER</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES SPANISH AMERICAN</b>		16. SOCIAL SECURITY NO. <b>479-12-0330</b>	17. INFORMANT <b>O. L. NIKELS, PLATTE CITY, MO. R.F.D.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerosis</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) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>8 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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 _____ a.m. _____ p.m. Month, Day, Year _____		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 <b>12-17-58</b> to <b>11-15-59</b> and last saw her/him alive on <b>11-15-59</b> Death occurred at <b>6:20 P</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22. SIGNATURE (Degree or title) <b>Frank Paul Laureyane MD</b>		22b. ADDRESS <b>428 S white ave</b>	22c. DATE SIGNED <b>11-15-59</b>
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-17-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SMITHVILLE, MO.</b>	23d. LOCATION (City, town, or county) (State) <b>Los Angeles, California</b>
24. FUNERAL DIRECTOR <b>MCCOMAS FUNERAL HOME,</b>		25. DATE RECD. BY LOCAL REG. <b>11-16-59</b>	26. REGISTRAR'S SIGNATURE <b>neva minshell</b>

DOCUMENT

BY AFFIDAVIT OF **Frank Paul Laureyane** MEDICAL CERTIFICATION

**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 Donald W. Hanks

Licensed Embalmer No. 4528

P. O. Address Smithville, 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.