

FILED AUG 14 1943 149

Primary Registration District No. 1002

3412

4838

1. PLACE OF DEATH:  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3014 E. 19th St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 18 Years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3014 E. 19th St.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME BENJAMIN ELATER BUTLER  
(b) If veteran, name war No  
(c) Social Security No. None

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month August day 5  
year 1943 hour 8 minute 20 P. M.

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Jesse 6. (c) Age of husband or wife if alive 61 years  
7. Birth date of deceased August 27, 1879  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 1942 to Aug 5 1943  
that I last saw him alive on Aug 5 1943  
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day  
63 11 8 hr. min.

Immediate cause of death Myocardial degeneration  
Due to Cirrhosis of Liver Duration 2 days  
Due to not known 18 mo

9. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

Other conditions (Include pregnancy within 3 months of death)  
124 R

10. Usual occupation Assistant Custodian

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business Board of Education  
12. Name Hiram Butler  
13. Birthplace New York  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Scofield  
15. Birthplace New York  
(City, town, or county) (State or foreign country)

16. (a) Informant Jesse Butler  
(b) Address 3914 E. 19th st.

17. (a) Burial (Buryal, cremation, or removal) (b) Date thereof 8-9-43  
(Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence no  
(c) Where did injury occur? no  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? no

18. (a) Signature of funeral director C. H. Blackman & Son,  
(b) Address Kansas City, Mo.

23. Signature Dean S. Pinner (M. D. or \_\_\_\_\_)  
Address 814 Professional Bldg Date signed 8-19-43

19. (a) 8-7-43 (b) P. E. Brown  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

AUG 23 1949

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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..... *H. Blackman* .....

Licensed Embalmer No. *3639* .....

P. O. Address..... *14. C. 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.**