

FILED AUG 14 1944

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. 3198

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:
Kansas City General Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Less than 24 hrs
(Specify whether)
 In this community 35 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. 3310 Virginia
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? 0 years.

3. (a) PRINT FULL NAME Laura Sickles Buttle

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John H. Buttle 6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased April 1 1879
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
<u>65</u>	<u>4</u>	<u>3</u>	hr. _____ min.

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER
 { 12. Name George Cook
 { 13. Birthplace New York New York
(City, town, or county) (State or foreign country)
 { 14. Maiden name Sarah Sickles
 { 15. Birthplace New York New York
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Richard S. Morro
 (b) Address 2620 E 34th KC Mo

17. (a) Burial (b) Date thereof 8-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cemetery - Mo

18. (a) Signature of funeral director J. F. O'Donnell
 (b) Address 3256 Broadway

19. (a) 8-5-44 (b) T. E. Brown (N.J.)
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4
 year 1944 hour 8:50 minute 0 M.

21. I hereby certify that I attended the deceased from Deputy Coroner to Coroner, 19____; that I last saw him alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction

Due to 940'

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____
 Of autopsy see above

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____ (e) Means of injury _____
 23. Signature C. E. Upster MD (M. D. or other) _____
 Address 2320d Melby Date signed 8/4/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Paul G. Rowe

Licensed Embalmer No. 2347

P. O. Address R. E. 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, above space should be left blank.