

S. No. 2
M-2-43
5-17-39
X35697

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 3 1947

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4758

Registrar's No. 789

Registration District No. 149

Primary Registration District No. 1002

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: K.C. Mem. Tbc. Hosp. D
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
In this community 23 yrs.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Jackson
(c) City or town K.C.
(If outside city or town limits, write "RURAL")
(d) Street No. 4016 Walnut
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Butterfield, Ben W.
3. (b) If veteran, name war no 3. (c) Social Security No. 487-07-7210

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month February day 24 year 1947 hour 19 minute 30 A. M.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from 2-10- 1947, to 2-21- 1947
that I last saw him alive on Feb 21 1947
and that death occurred on the date and hour stated above.

7. Birth date of deceased July 31 1903
(Month) (Day) (Year)

Immediate cause of death Spontaneous Pneumothorax
Pulmonary Tuberculosis
Due to _____

8. AGE: Years 43 Months 7 Days 20 If less than one day hr. _____ min. _____

Due to _____
Other conditions (include pregnancy within 3 months of death) _____
Major findings: 13K
Of operations _____
Of autopsy _____

9. Birthplace Husbrock Heights N.J.
(City, town, or county) (State or foreign country)
10. Usual occupation Pharmacist
11. Industry or business _____
12. Name Milton G. Butterfield
13. Birthplace Dawson
(City, town, or county) (State or foreign country)
14. Maiden name Lillian Dyer
15. Birthplace Kansas
(City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant KCTB
(b) Address K.C. Mo.
17. (a) Buried (b) Date thereof Feb 22 1947
(Burial, cremation or removed) (Month) (Day) (Year)
(c) Place: burial or cremation Pilane Kansas
18. (a) Signature of funeral director Robert G. Shaw
(b) Address Kansas City, Mo. (E. C. Shaw)
19. (a) 2-21-47 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

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? _____
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature M. B. Rosenberg (M. D. or other) _____
Address K.C. T. B. Hosp. Date signed 2-21-47

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

MOTHER FATHER

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

George M. Malley

Licensed Embalmer No. *2798*

P. O. Address *W. C. Kansas*

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.