

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:  
General Hospital No. 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 12 days  
(Specify whether years, months or days)  
In this community 62 YEARS

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. 1901 E. 37  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William D. Butt  
3. (b) If veteran, NO name war \_\_\_\_\_  
3. (c) Social Security No. NO

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month May day 18  
year 1948 hour 1 minute P. M.

4. Sex MO 5. Color or race W  
6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife LENA BUTT  
6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased JAN 13 1880  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 6, 1948 to May 18, 1948  
that I last saw him alive on May 18, 1948  
and that death occurred on the date and hour stated above.

8. AGE: Years 68 Months 4 Days 5  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Carcinoma of larynx  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

10. Usual occupation RETIRED

11. Industry or business \_\_\_\_\_  
12. Name IRVIN, W. BUTT  
13. Birthplace OHIO  
(City, town, or county) (State or foreign country)  
14. Maiden name ELLEN E. HENRY  
15. Birthplace ILL.  
(City, town, or county) (State or foreign country)

Major findings: 47a  
Of operations \_\_\_\_\_  
Of autopsy See above  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant LENA BUTT  
(b) Address 1901 E. 37TH  
17. (a) BURIAL (b) Date thereof 5/20/48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation MT MORIAH

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? \_\_\_\_\_

18. (a) Signature of funeral director STINE & McELVEE  
(b) Address K. E. MO.  
19. (a) 5-20-48 (b) Sheraldine Holman  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury C  
23. Signature Wm W. Hart (M. D. or other) MD  
Address Med. Dir. Gen'l Hosp. Date signed 5-19-48

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

MOTHER, FATHER

*Dr. Williams*

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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 *[Signature]*  
Licensed Embalmer No. *1413*  
P. O. Address *[Signature]*

**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.**