

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-025123
STATE FILE NUMBER

FILED JUL 22 1958

Registration District No. 120

Primary Registration District No. 4197

Registrar's No. 228

80
300
1-57

1. PLACE OF DEATH a. COUNTY <u>Gentry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Stearns</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Stearnsberry</u>		c. CITY OR TOWN <u>Stearnsberry</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>444 W. Gentry</u>		d. STREET ADDRESS (If outside, give location) <u>N. Gentry Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Clyde Earl Butterbaugh</u>		4. DATE OF DEATH <u>July 12-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drug Store</u>	11. BIRTHPLACE (City and state or country) <u>Kalona - Iowa</u>
13a. FATHER'S NAME <u>Joseph Butterbaugh</u>		13b. MOTHER'S MAIDEN NAME <u>Candice Boyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u>		17. INFORMANT <u>Mrs. Sarah Kurtzright</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>150X</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>Stearnsberry MO</u>	
21. I attended the deceased from <u>May 1-58</u> to <u>July 12-58</u> and last saw <u>him</u> alive on <u>July 12-1958</u> Death occurred at <u>Five Forty P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>R. J. Milligan M.D.</u>	
22b. ADDRESS <u>Stearnsberry MO</u>		22c. DATE SIGNED <u>7-14-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>7-14-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>High Ridge</u>	23d. LOCATION (City, town, or county) (State) <u>Stearnsberry Stearns MO</u>
24. FUNERAL DIRECTOR <u>Robert G. Phillips</u>		25. DATE RECD. BY LOCAL REG. <u>7-14-58</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. L. W. Bare</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *Leroy A. Phillips*.....

Licensed Embalmer No. *1898*.....
P. O. Address *Staub...*.....

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.