

No. 2
12-45
17-39
K47070

FILED JAN 7 1947

State File No. _____

Registration District No. 294

Primary Registration District No. 3056

Registrar's No. 274

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Heber Springs
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Woodland Hospital
(If not in hospital or institution, write street number of location)

(d) Length of stay: In hospital or institution four days
(Specify whether in this community 85 years)
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Clark
(If outside city or town limits, write "RURAL")

(d) Street No. none
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME LUELLA BUTTS

3. (b) If veteran, name war none

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December 26th
year 1946 hour 6 minute 10 P.M.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife James W. Butts 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: February - 4 - 1853
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 2 Dec. 22 1946, to Dec 26 1946
that I last saw her alive on Dec. 26 1946
and that death occurred on the date and hour stated above.

8. AGE: Years 93 Months 10 Days 22
If less than one day _____ hr. _____ min.

Immediate cause of death: Chronic myocarditis

Due to Intertrochanteric fracture of the left hip

Other conditions: _____
(Include pregnancy within 3 months of death)

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings: _____
Of operations: _____

Of autopsy: _____

ADDITIONAL SUPPLEMENTARY

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

(a) Accident, suicide, or homicide (specify RECORDED)

(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? 0

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Mrs. J. L. ... (Date of or other) _____
Address Madison, Missouri Date signed 12-27-46

MOTHER FATHER

12. Name Mason S. Bonnell

13. Birthplace Howard Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Lucy Evans

15. Birthplace Howard Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Harry Bailey

(b) Address Clark, Missouri

17. (a) Burial (b) Date thereof Dec-28-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Clark, Missouri

18. (a) Signature of funeral director Snow Funeral Home

(b) Address Heber Springs, Missouri

19. (a) Dec 28-46 (b) Leola Williams
(Date received local registrar) (Registrar's signature)

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

RECEIVED
District Health Officer No. 10
Date of JAN - 6 1947

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 R. M. Carter

Licensed Embalmer No. 4117

P. O. Address Woburn 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.

Registration District No. *294*

Primary Registration District No. *3056*

1. PLACE OF DEATH

(a) County *Randolph*
 (b) City or town *Moberly*
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether

In this community _____
years, months or days)

3. (a) PRINT FULL NAME *Luella Butts*

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex *F* 5. Color or race *W* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Feb 4*
(Month) (Day) (Year)

8. AGE: Years *93* Months _____ Days _____ If less than one day
 hr. _____ min. _____

9. Birthplace _____ *Mo*
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____
 13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Year *1946* hour _____ minute _____ M.

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

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(a) Accident, suicide, or homicide (specify) *accident*

(b) Date of occurrence *Dec-20-47*

(c) Where did injury occur? *Moberly Mo*
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? *Home - Dizzy + fall*

While at work? *yes* (Specify type of place) (e) Means of injury *Fall*

23. Signature *Thos. J. Murray* (M. D. or other) _____

Address *Moberly Mo* Date signed *1-4-47*

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

SUPPLEMENTARY

Hoses

41092