

No. 2  
M-5-43  
5-17-39  
I X36671

FILED SEP 22 1947  
Registration District No. 270

Primary Registration District No. 4427

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

1. PLACE OF DEATH:

(a) County Pulaski  
 (b) City or town Waynesville  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Waynesville General 0  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 hrs. 45 min  
(Specify whether years, months or days)

In this community 4 hrs. 45 min  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski 85  
 (c) City or town Waynesville 0  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location) 0  
 (e) Citizen of foreign country? NO 0  
(Yes or No)  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bruce Gay Butler  
 3. (b) If veteran, name war \_\_\_\_\_  
 3. (c) Social Security No. \_\_\_\_\_

4. Sex male 0  
 5. Color or race W  
 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
 6. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased 8 - 26 - 47  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_  
 If less than one day 4 hr. 45 min.

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

10. Usual occupation \_\_\_\_\_  
 11. Industry or business \_\_\_\_\_

MOTHER FATHER {  
 12. Name Earl Butler  
 13. Birthplace Columbus Kans.  
(City, town, or county) (State or foreign country)  
 14. Maiden name Edna Josephine Bishop  
 15. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Earl Butler  
 (b) Address St. James, Mo.  
 17. (a) Burial (b) Date thereof 8-27-47  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Mercy Cem

18. (a) Signature of funeral director Carl E. Lichliter  
 (b) Address St. James Mo.  
 19. (a) Sept 15, 1947 (b) Shelma C. Sacht  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 26  
 year 1947 hour 7 minute 25 P.M.  
 21. I hereby certify that I attended the deceased from 8-26  
 \_\_\_\_\_, 1947 to 8-26, 1947  
 that I last saw him alive on 8-26, 1947  
 and that death occurred on the date and hour stated above.

Immediate cause of death cerebral hemorrhage  
 Duration 4 hr. 45 min.

Due to Forceps  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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) \_\_\_\_\_  
 (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) (a) Means of injury  
 23. Signature E. E. Ford M.D. (M. D. or other) 0  
 Address Rolls 2nd Date signed 8-24-47

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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.....

*Not Embalmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.**