

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

FILED NOV 6 1945

State File No. _____

Registration District No. 43

Primary Registration District No. 40-57-5135

Registrar's No. 271

1. PLACE OF DEATH:

(a) County Butler

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

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 22 year
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler

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

(d) Street No. _____ (If rural, give location) _____

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

If yes, name country _____

3. (a) PRINT FULL NAME John H. Bulger

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race white

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____

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

7. Birth date of deceased September 25 1945
(Month) (Day) (Year)

8. AGE: Years 83 Months _____ Days _____

If less than one day hr. _____ min. _____

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name Unknown 9

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

16. (a) Informant San Henry

(b) Address Dixie

17. (a) Burial (b) Date thereof Sept 26 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dixie Cemetery

18. (a) Signature of funeral director Charles Ernest H...

(b) Address Cambridge Mo

19. (a) 10/1/45 (b) R. A. Minch
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 25
year 1945 hour 12 minute 20 P. M.

21. I hereby certify that I attended the deceased from Sept. 2 1945 to Sept 25 1945
that I last saw him alive on Sept. 24 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

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

Major findings: 830

Of operations _____

Of autopsy _____

Duration _____

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) _____

(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 _____

23. Signature H. J. Rutledge (M. D. or other) MD

Address Cambridge Mo Date signed 9/24/45

RECEIVED

District Health Office No. 2

District File Number 1015-3

Date Filed 10-31-4

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 Christine M. Landers

Licensed Embalmer No. 4227

P. O. Address Campbell, Md

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 271

Registration District No. 43 Primary Registration District No. 5130

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Rural Ash Hill Twp
(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)

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 _____

3. (a) PRINT FULL NAME John H. Bulger
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced WIDOWED
6. (c) Age of husband or wife if alive _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ M. Day _____ year 1940 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 _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)
8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. _____ min.
9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation _____
11. Industry or business _____
MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name _____ (City, town, or county) _____ (State or foreign country)
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)
16. (a) Informant _____
(b) Address _____
17. (a) _____ (b) Date thereof _____ (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)

Duration _____
Due to _____
Due to _____
Other conditions _____ (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
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 _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

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

33283