

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County Laclede
Township Grant
City (No.) (Ward)

Registration District No. 238
Primary Registration District No. 5327

File No. 10086
Registered No.
St. Ward)

2. FULL NAME

(a) Residence. No. St. Ward)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Wright

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 20 - 1838

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
90 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Sept. Co. Illinois

10. NAME OF FATHER

Jacob Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Kentucky

12. MAIDEN NAME OF MOTHER

Rebecca Stone

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Tennessee

14. INFORMANT

(Address) Geo. Wright Golden City, Mo.

15. FILED

3-24-29 J. A. Minn REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 21 1929

17. I HEREBY CERTIFY That I attended deceased from Oct 14, 1928, to March 21, 1929 that I last saw him alive on March 17, 1929, and that death occurred, on the date stated above, at 7:00 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic interstitial Nephritis
131

at least one year
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

1/29/29
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical

(Signed) J. A. Minn, M. D.

Mar 22, 1929 Address Golden City Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

D.O.F. Golden City Mo. 3/23 1929

20. UNDERTAKER

ADDRESS

E. A. Phillips Golden City Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

29
20
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1929

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2
2
2

