

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.

11-11-36  
 APR 17 1936

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

Do not use this space.

10137

1. PLACE OF DEATH *Greene*  
 County ..... Registration District No. *318*  
 Township *Springfield* Primary Registration District No. *12091*  
 City *Springfield* (No. *Baptist Hospital*) Registered No. *190*  
 St. ..... Ward .....  
 2. FULL NAME *Mrs. Carrie E. Wright*  
 (a) Residence, No. *Jola* St. *Kansas* Ward .....  
 (Usual place of abode) (If nonresident, give city or town and State)  
 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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   
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *July 31 - 1876*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
*59 8 3*  
 OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *House work*  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *In home*  
 10. Date deceased last worked at this occupation (month and year) ..... 11. Total time (years) spent in this occupation   
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*  
 FATHER  
 13. NAME *Wm H. Aubrey*  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*  
 MOTHER  
 15. MAIDEN NAME *Clara L. Burnett*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ky*  
 17. INFORMANT (ADDRESS) *Henry Aubrey Springfield, Mo.*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Jola, Kansas* DATE *March 6, 1936*  
 19. UNDERTAKER (ADDRESS) *Whechel Funeral Home Branson, Mo.*  
 20. FILED *3/5* 19 *36* *Ralph W. Langston* Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 4, 1936*  
 22. I HEREBY CERTIFY, That I attended deceased from *March 1, 1936*, to *March 4, 1936*  
 I last saw *her* alive on *March 1, 1936* Death is said to have occurred on the date stated above, at *2 P.* m.  
 The principal cause of death and related causes of importance were as follows:  
*Arteriosclerosis*  
*result of*  
 Other contributory causes of importance:  
*Chronic Nephritis*  
*181*  
 Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. ....  
 Manner of injury .....  
 Nature of injury .....  
 24. Was disease or injury in any way related to occupation of deceased? .....  
 If so, specify .....  
 (Signed) *Hellie Smith* M. D.  
*Springfield, Mo*

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