

AUG 25 1937

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

Do not use this space.

1. PLACE OF DEATH

County GreeneTownship BrookfieldCity Brookfield (No. 494)Registration District No. 494Primary Registration District No. 3025File No. 27681Registered No. 50

St. _____

Ward _____

2. FULL NAME George W. Wright(a) Residence, No. 418 McSwain St. _____

Ward _____

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OF RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ann Wright6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6 - 1895

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
41 10 1

8. Trade, profession, or particular kind of work done, as spinning, sawyer, bookkeeper, etc. RB Foreman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) May - 37 11. Total time (years) spent in this occupation 2512. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Macon Mo13. NAME W. S. Wright14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rapids Mo15. MAIDEN NAME Anna Bennie16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Alb. Ind17. INFORMANT Ann Wright (ADDRESS) 418 McSwain18. BURIAL, CREMATION, OR REMOVAL PLACE Road Hill DATE July 9 3719. UNDERTAKER Hunter & Callaway (ADDRESS) Brookfield20. FILED Aug 9 37 W. H. H. H. H. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 7 193722. I HEREBY CERTIFY, That I attended deceased from July 6, 1937, to July 7, 1937I last saw him alive on July 7, 1937. Death is saidto have occurred on the date stated above, at 11 P. M.

The principal cause of death and related causes of importance were as follows:

Cerebral ThrombosisDate of onset July 6 37

Other contributory causes of importance:

Hemolytic Streptococcus Septicemia June 30 37Name of operation None Date of _____What test confirmed diagnosis? Clinical Was there an autopsy? No

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 124. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) J. E. Evans, M. D.(Address) Brookfield, 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.

