

FILED FEB 13 1940

Registration District No. 218

Primary Registration District No. 2001

Registrar's No.

33

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Burge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 6 days (Specify whether
 In this community 6 days years, months or days)

3. (a) PRINT FULL NAME ALICE WRIGHT 628. (b) If veteran,
name war3. (c) Social Security
No.

4. Sex Female 5. Color or race W
 6. (b) Name of husband or wife Doc Wright 6. (a) Single, widowed, married,
 divorced Married
 7. Birth date of deceased Sept. 4 1907 6. (c) Age of husband or wife if
 alive 45 years
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
32 4 6 hr. min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Home work

11. Industry or business

MOTHER FATHER
 12. Name J. N. Moore
 13. Birthplace no record (City, town, or county) (State or foreign country)
 14. Maiden name Ellen Roberts
 15. Birthplace no record (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Doc Wright(b) Address 813 South St.17. (a) Burial (b) Date thereof Jan 13, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Hazelwood, Can.18. (a) Signature of funeral director Fred C. Baer(b) Address Springfield, Mo.19. (a) 1/11/40 (b) Chas A. Deane, Jr.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Springfield, Mo.
 (If outside city or town limits, write "RURAL")
 (d) Street No. 813 South St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 10
year 1940 hour 11:05 minute _____ P. M.21. I hereby certify that I attended the deceased from
1, 4, 40, 19____ to 1, 10, 40, 19____;
that I last saw her alive on 1, 10, 40, 19____;and that death occurred on the date and hour stated above.
Immediate cause of death Peritonitis following
Appendectomy, ovariectomy and
salpingotomy ✓Due to _____ 6 days

Due to _____

Other conditions
* (Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

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? _____

(e) While at work? _____ (Specify type of place)
(f) Means of injury _____23. Signature J. Musick (M. D. or other)
Address Springfield, Mo. Date signed 1, 11, 40

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EXHIBIT BUREAU

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.....

Self

....., Registered Apprentice No.....

working under my personal supervision.

Signed *R. H. Williams*

Licensed Embalmer No. *3681*

P. O. Address *Springfield, Mo.*

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, above space should be left blank.

X

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

2370
Do not use this space.

1. PLACE OF DEATH
 (a) County Greene Registration District No. 318
 (b) Townships Springfield Primary Registration District No. 2001 Registered No. 33
 (c) City Springfield (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Alice Wright
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED m
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
32 4 6

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 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)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 10 1940

22. I HEREBY CERTIFY, That I attended deceased from _____ 19____ to _____ 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

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

Peritonitis following appendectomy, 25N
 Date of onset _____

Other contributory causes of importance:
ovarectomy & salpingectomy were performed for H.C. - not a puerperal case.

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) J. D. Mueser, M. D.

(Address) Springfield Mo

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PH. No. and date of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENT

