

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5753

Registration District No. 11

Primary Registration District No. 4008

Registrar's No. 26

1. PLACE OF DEATH:

(a) County Andrew
 (b) City or town Fillmore
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether)
 In this community 40 yrs.
years, months or days

3. (a) PRINT FULL NAME Luke Wright
 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 wid
 6. (b) Name of husband or wife Carrie in an arm
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 10 (Month) 1867 (Day) (Year)

8. AGE: Years 76 Months 11 Days 21
 If less than one day hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER
 12. Name Lewis Wright
 13. Birthplace not known (City, town, or county) 9 (State or foreign country)
 14. Maiden name Martha Shunk
 15. Birthplace not known (City, town, or county) 9 (State or foreign country)

16. (a) Informant's own signature Mrs. Minnie M. Cole
 (b) Address Fillmore MO
 17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-4-1940 (Month) (Day) (Year)
 (c) Place: burial or cremation Fillmore

18. (a) Signature of funeral director E. B. Brest
 (b) Address Savannah MO
 19. (a) Feb 3, 1940 (Date received local registrar) (b) Mar. Addie Barnes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew
 (c) City or town Fillmore
(If outside city or town limits, write "RURAL")
 (d) Street No. 0
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 1 1940
 year 1940 hour 1 minute 25 M.
 21. I hereby certify that I attended the deceased from 1938 Jan - 1 to Feb 1 1940
 and that I last saw him alive on Feb - 1 1940
 and that death occurred on the date and hour stated above

Immediate cause of death Coronary Occlusion Duration _____

Due to Arterio-Sclerosis

Due to Diabetes Mellitus

Other conditions (Include pregnancy within 3 months of death) 54

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? ✓

11 While at work? _____ (Specify type of place) (e) Means of injury _____
 23. Signature M. L. Holliday (M. D. or other) M.D.
 Address Fillmore MO Date signed 2/1/40

RECEIVED
District Health Officer No. 11;
District File Number 340-32-0
Date Filed MAR 13 1940

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 E. C. Breit
Licensed Embalmer No. 2650
P. O. Address Sovannah, Ga

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 5763
Registrar's No. 25-

Registration District No. 11

Primary Registration District No. 4008

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

1. PLACE OF DEATH:

(a) County Andrew
(b) City or town Fillmore
(If outside city or town limits, write "RURAL" and name of township)
(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)

3. (a) PRINT FULL NAME Luke Wright

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..... w

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... years

7. Birth date of deceased.....
(Month) 2 (Day) 10 (Year) 1863

8. AGE: Years 76 Months 11 Days 21 If less than one day..... min.

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

10. Usual occupation Farmer

11. Industry or business.....

MOTHER FATHER

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) April 3 1940 (b) Mrs. Addie Burner
(Date received local registrar) (Registrar's signature)

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) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 2 day 1
year 1940 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....
.....
.....

Due to.....
.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
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?
.....
(Specify type of place) (e) Means of injury.....

23. Signature M. L. Holliday (M. D. or other)

Address Fillmore Mo. signed.....

SUPPLEMENTAL

S-5753