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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34582

FILED NOV 12 1940

Registration District No. 1099

Primary Registration District No. 1002

Registrar's No. 4008

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

1. PLACE OF DEATH:

(a) County Jackson.

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Kansas City Municipal Tuberculosis Hospt.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 year - 3 mo - 7 da (Specify whether)

In this community 30 years. 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson.

(c) City or town Kansas City.
(If outside city or town limits, write "RURAL")

(d) Street No. 3014 Tracy Avenue
(If rural, give location)

0

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

3. (a) PRINT FULL NAME Daniel Wright

3. (b) If veteran, name war

3. (c) Social Security No. 486-10-5702

4. Sex Male.

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Grace.

6. (c) Age of husband or wife if alive 46 years

7. Birth date of deceased Feb. - 10 - 1894
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
46	8	14	hr. min.

9. Birthplace St Joseph. Missouri 0
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer. 1

11. Industry or business 1

FATHER
12. Name Daniel Wright
13. Birthplace Kansas
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Cora Hambrie
15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant K.C.M. T.B. Hospt.
(b) Address Leeds Station.

17. (a) Burial (b) Date thereof 10/26/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Mellody-McGilley
(b) Address K. C. Mo.

19. (a) 10-25-40 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 24
year 1940 hour 4:45 a.m. minute M.

21. I hereby certify that I attended the deceased from July 17, 1940, to Oct. 24, 1940;
that I last saw him alive on Oct. 24, 1940;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	
Due to 23	
Due to	
Other conditions (Include pregnancy within 3 months of death) Uremia - Myocardial failure	

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?
(Specify type of place)
While at work? (e) Means of injury 1

23. Signature O. C. Hayes [illegible] (M. D. or other)
Address K. C. Tb. Hospital, Kansas City, Mo. Date signed Oct 24 1940.

(Licensed Embalmer's Statement on Reverse Side)

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, ~~only~~ .....

....., Registered Apprentice No. 267

working under my personal supervision.

Signed .....

Licensed Embalmer No. 2999

P. O. Address K.C. Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.