

No. 2  
4-13-40  
-17-39  
X23159

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **41853**  
Registrar's No. **1296**

Registration District No. **85**  
Primary Registration District No. **1001**

1. PLACE OF DEATH:  
(a) County **Buchanan**  
(b) City or town **St. Joseph**  
(c) Name of hospital or institution: **Mercy Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1 hour**  
In this community **23** hours  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Barbara Joan Wright**  
(b) If veteran, name war **None**  
(c) Social Security No. **None**

4. Sex **Female**  
5. Color or race **White**  
6. (a) Single, widowed, married, divorced **Infant**  
(b) Name of husband or wife **None**  
(c) Age of husband or wife if alive **XXX** years  
7. Birth date of deceased **December 9, 1940**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**0 0 0 21 hr. min.**

9. Birthplace **St. Joseph, Mo.**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Infant**  
11. Industry or business **None**

12. Name **George Wright**  
13. Birthplace **Easton, Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Maxine Dillon**  
15. Birthplace **St. Joseph, Missouri**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Father George Wright**  
(b) Address **415 Virginia, City**

17. (a) **Burial**  
(Burial, cremation, or removal) (b) Date thereof **Dec. 11, 1940**  
(Month) (Day) (Year)  
(c) Place: burial or cremation **Asland Cemetery, City**

18. (a) Signature of funeral director **John E. Ruff**  
(b) Address **6054 Pryor Ave.**

19. (a) **12-13-1940**  
(Date received local registrar) (b) **D. Nestleburgh**  
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **Buchanan**  
(c) City or town **St. Joseph**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **415 Virginia**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **12** day **10**  
year **40** hour **4** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **7:30**  
**12-10**, 19**40** to **12-10-430**, 19**40**  
that I last saw **her** alive on **12 10**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Insufficient Heart**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_

23. Signature **Blanch B. Rasmick** (M.D. or other) **DR**  
Address **222 Logan Bldg** Date signed **12-13**

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

1  
5  
7

*For Burial  
Lynette Bledy.*

**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.....

Myself

Registered Apprentice No.....

working under my personal supervision.

Signed..... *John E. Puff*

Licensed Embalmer No. 3986

P. O. Address 6054 Fryor Ave., City

**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, fact should be so stated above.**