

Registration District No. **398**

Primary Registration District No. **5554**

Registrar's No. **13**

48000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Jackson B. Mo. Co.
 (b) City or town Manassas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
418 Farley Terrace
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1
 (Specify whether
 In this community 25 years
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson
 (c) City or town Manassas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 418 Farley Terrace
 (If rural, give location) 0
 (e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRIMARY FULL NAME Chris C. Wright
 3. (b) If veteran, name war no 3. (c) Social Security No. no
 4. Sex Male 5. Color white 6. (a) Single, widowed, married, divorced single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Sept. 27-1957
 (Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Jan day 10
 year 1941 hour 5 minute 45 P.M.
 21. I hereby certify that I attended the deceased from 12-21-40
 _____, 19____, to 1-10-41, 19____;
 that I last saw him alive on 1-10-41, 19____;
 and that death occurred on the date and hour stated above.

8. AGE: Years 82 Months 3 Days 14 If less than one day _____ hr. _____ min.
 9. Birthplace 0 Missouri
 (City, town, or county) (State or foreign country)
 10. Usual occupation Carpenter

Immediate cause of death LOBAR PNEUMONIA
 Duration 1 wk
 Due to UREMIA 3 wks
 Due to CHRONIC NEPHRITIS 9 mo
 Other conditions _____
 (Include pregnancy within 3 months of death)

11. Industry or business _____
 12. Name Carl Wright
 13. Birthplace Ky - 1
 (City, town, or county) (State or foreign country)
 14. Maiden name Mary A. Honey
 15. Birthplace Va
 (City, town, or county) (State or foreign country)
 16. (a) Informant Leon Wright
 (b) Address 1139-W-41 St Terrall
 17. (a) Removal (b) Date thereof 1/13/41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Miami Mo
 18. (a) Signature of funeral director Mr C. R. Foster
 (b) Address 918 Brooklyn W.C. Mo
 19. (a) Jan. 13, 1941 (b) Dr. L. Cook M.D.
 (Date received local registrar) (Registrar's signature)

Major findings: _____
 Of operations _____
 Of autopsy _____
 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?
360 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature J. H. Haffner (M. D. or other) M.D.
 Address 925 Hazel St. W.C. Mo Date signed 1/11/40

J. L. Shepper
1493424
aug 16 89

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 *me*

....., Registered Apprentice No.
working under my personal supervision.

Signed

J. L. Shepper

Licensed Embalmer No. *4179*

P. O. Address

Kansas City, 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, fact should be so stated above.