

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

20920

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2450

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
548 Main
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Unknown
(Specify whether)

In this community Unknown
years, months or days

3. (a) PRINT FULL NAME GEORGE WRIGHT

3. (b) If veteran, name war Unknown 3. (c) Social Security No. _____

4. Sex OM 5. Color or race W 6. (a) Single, widowed, married, divorced Unknown

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

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>about 80</u>			hr. min.

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

10. Usual occupation Unknown

11. Industry or business _____

12. Name Unknown

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Coroner

(b) Address Court House

17. (a) Burial (b) Date thereof 6/25/41
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn
(Delhi) J. Carrall

18. (a) Signature of funeral director _____
(b) Address 901 E 5th

19. (a) 6/27/41 (b) M. M. Crown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

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

(d) Street No. 548 Main 0
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 23 year 41
hour _____ minute _____

21. I hereby certify that I attended the deceased from 1:50 P.M.
_____, 19____, to _____, 19____;
that last seen alive on _____, 19____,
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Certificate signed by inspection
No diagnosis possible

Due to _____
Other conditions (Include pregnancy within 3 months of death) 200C

Major findings: 200C
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?
While at work? _____ (Specify type of place)
Means of injury: _____

23. Signature W. M. ... (M. D. or other)
Address K. C. Mo Date signed _____

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 _____

Licensed Embalmer No. 2566

P. O. Address 1807 E 29th

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.