

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2779

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Jackson City  
(c) Name of hospital or institution: Trinity Lutheran  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 07 days  
(Specify whether years, months or days) 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
(c) City or town N.E. 3rd  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2106 E 33  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? Am. years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 23  
year 1941 hour 6:00 minute - P. M.  
21. I hereby certify that I attended the deceased from July 15th 1941, to July 23 1941;  
that I last saw her alive on July 23 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia (terminal) Duration 3 days

Due to 10:20  
Due to 10:20

Other conditions Cholecystomy 172 Days 10  
(Include pregnancy within 3 months of death)

Major findings: Intestinal obstruction of lower ileum (post-operative)  
Broncho-pneumonia - Cardiac hypertrophy  
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? \_\_\_\_\_

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

23. Signature Barrick Wilson (M. D. or other) MD  
Address 1025 Realto Bg Date signed July 24/41

3. (a) PRINT FULL NAME WRIGHT, GENIVIE L.

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

4. Female 5. Color or race White 6. (a) Single, widowed, married, divorced, Widow

(b) Name of husband or wife Townsend Wright (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 6, 1860  
(Month) (Day) (Year)

8. AGE: 80 Years 8 Months 17 Days If less than one day hr. \_\_\_\_\_ min.

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

10. Usual occupation housewife

11. Industry or business \_\_\_\_\_

12. Name Jerry Sanders

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

14. Maiden name Margaret Jennings

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

16. (a) Informant mo. locally trust

(b) Address 5120 Brookwood

17. (a) Burial (b) Date thereof 7-26-41  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation First Hill Cem

18. (a) Signature of funeral director SUDARTH

(b) Address 7/24/41 N.E. 3rd  
(Date received local registrar) (Registrar's signature)

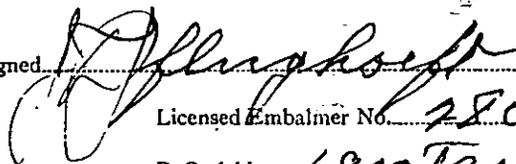
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

18  
3  
8

**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. 2806

P. O. Address. 6900 Transit N. C.

**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.**