

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 2 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31048**
Registrar's No. **937**

Registration District No. **85**

Primary Registration District No. **1001**

1. PLACE OF DEATH:
(a) County **Buchanan**
(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
601 Blake St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community **43 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Buchanan** **11**
(c) City or town **St. Joseph** **1**
(If outside city or town limits, write "RURAL") **7**
(d) Street No. **601 Blake St.** **11**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? **52 years** years.

3. (a) PRINT FULL NAME **John B. Wright**
3. (b) If veteran, name war **no**
3. (c) Social Security No. **none**

4. Sex **Male** 0 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Katie Wright**
6. (c) Age of husband or wife if alive **63** years
7. Birth date of deceased **Oct. 21, 1866**
(Month) (Day) (Year)

8. AGE: Years **74** Months **10** Days **16**
If less than one day _____ hr. _____ min.

9. Birthplace **Edinburgh** **Scotland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Veterinarian, Meat Insp.**

11. Industry or business **Bureau of Animal Industry**

MOTHER FATHER {
12. Name: **James Wright** **4**
13. Birthplace **Scotland** (State or foreign country)
14. Maiden name **Unknown** (State or foreign country)
15. Birthplace **?** (State or foreign country)

16. (a) Informant **Mrs. Katie Wright**
(b) Address **601 Blake St.**

17. (a) **Burial** (b) Date thereof **Sept. 9, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ashland Cem.**

18. (a) Signature of funeral director **Black Mortuary**
(b) Address **5025 King Hill Ave.**

19. (a) **Sept 8, 1941** (b) **J. Nestlebuch**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **7**
year **1941** hour **5** minute **15 a** M.

21. I hereby certify that I attended the deceased from **Sept. 7** 19**41** to **Sept. 7** 19**41**
that I last saw him alive on **Sept. 6** 19**41**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Coronary Artery - Interspersed below normal**
Due to **the disease (Liner - Primary Seat)**
Due to _____

Duration **14p**

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **H67**
Of operations _____
Of autopsy **Above diagnosis**

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 **J. P. Emerson** (M. D. or other) **EMD**
Address **St. Joseph** Date signed **9/10/41**

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

OCT 2

1944

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, ~~on~~ by Sept. 7, 19

Carl Clark

....., Registered Apprentice No.

working under my personal supervision.

Signed

Carl Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph, 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.