

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4502

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether
years, months or days)
In this community 17 years

3. (a) PRINT FULL NAME LAFAYETTE WRIGHT

3. (b) If veteran, name was No 3. (c) Social Security No. None

4. Sex Male 5. Color or race 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 February 20 1857
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 8 9 hr. min.

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

10. Usual occupation Retired

11. Industry or business Farmer

12. Name Enoch D. Wright

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Matilda Moreland
(City, town, or county) (State or foreign country)

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

16. (a) Informant Frank Ewing

(b) Address 3409 Locust St.

17. (a) Removal (b) Date thereof 1-1-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Craig, Missouri

18. (a) Signature of funeral director Freeman Mortuary

(b) Address Kansas City, Missouri

19. (a) Dec. 31 1941 (b) M. M. Crown
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
Kansas City
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. 3409 Locust St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 29th
year 1941 hour 11 minute 35 P. M.

21. I hereby certify that I attended the deceased from 12-28-41 to 12-29-41, 19____;
that I last saw him alive on 12-29-41, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture of femur, due to accidental fall in home and Senility

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence 12.3

(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 Dr. R. Thorn (M. D. or other) 0

Address Med. Dir. K.C. Gen. Hospital Date signed _____

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

18
20

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 Clarence W. Chiles

Licensed Embalmer No. 3473

P. O. Address 76 E 760

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **41 211**

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

1. PLACE OF DEATH:

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

3. (a) PRINT FULL NAME **Lafayette Wright**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **S**

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

7. Birth date of deceased **Feb 20 1864**
(Month) (Day) (Year)

8. AGE: Years **84** Months **8** Days **18**
(If less than one day, in min.)

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

10. Usual occupation.....

11. Industry of business.....

12. Name.....

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits, write "RURAL")
(d) Street No..... (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month **Dec** day **29**
year **1941** hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Fracture of femur
Due to.....

Due to.....

Other conditions **Parkinsonian tremors;**
(Include pregnancy within 3 months of death)
and myocardial insufficiency

Major findings:
Of operations.....

Of autopsy..... **1960**
14

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) **See above diagnosis**

(b) Date of occurrence **Not recorded 123**

(c) Where did injury occur? **History of falling at home**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
home

While at work? (Specify type of place) Means of injury.....

23. Signature **Drury R. Thom** (M. D. or other) **0**

Address **Med. Dir. K/C Gen. Hospital** Date signed.....

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

SUPPLEMENTARY

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-41211