

FILED OCT 5 1942

Registration District No. **49**

Primary Registration District No. **1002**

Registrar's No. **3569**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Jackson City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Gen'l Hosp. No. 2**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **40 yrs.** (Specify whether years, months or days)

In this community **40 yrs.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Jackson**

(c) City or town **Jackson City**
(If outside city or town limits, write "RURAL")

(d) Street No. **1127 Pacific**
(If rural, give location)

(e) Citizen of foreign country? **no.** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Willie F. Bright**

3. (b) If veteran, name war _____

3. (c) Social Security No. **no**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **20** year **1942** hour **12:55** minute **noon** M.

21. I hereby certify that I attended the deceased from **24 July 1938** to **19** _____

that I last saw him alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Myocarditis**

Due to **Hypertensive Heart Disease**

Other conditions **939**

4. Sex **m**

5. Color or race **Col**

6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years _____ months _____ days

7. Birth date of deceased: **Mar 2 1890**
(Month) (Day) (Year)

Physician **D. J. Brouer**

Duration _____

Major findings: Of operations _____

Of autopsy **Imp.**

Underline the cause to which death should be charged statistically.

8. AGE: Years **52** Months **6** Days **18** If less than one day hr. _____ min. _____

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

10. Usual occupation **Laborer**

11. Industry or business _____

MOTHER FATHER

12. Name **Unknown**

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

14. Maiden name **Unknown**

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

16. (a) Informant **Emma Hilgard**

(b) Address **1312 Garfield**

17. (a) **burial** (b) Date thereof **1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nestlawn R.C.M.**

18. (a) Signature of funeral director **Adkins Bros.**

(b) Address **2000 E. 42th St. Mo.**

19. (a) **9-29-42** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

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 **P. P. Richardson** (M. D. or other)

Address **1832 Fair** Date signed **9-26-42**

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

A. T. Moore

Licensed Embalmer No.

948

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No.

Primary Registration District No.

Registrar's No. 3569

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town.....
(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.....
In this community..... (Specify whether
years, months or days)

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

3. (a) PRINT FULL NAME Willie Bright

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

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

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

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

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

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

17. (a) Burial (b) Date thereof 10-10-42
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

(b) Address.....

19. (a) 10/10/42 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH Month..... day.....
year..... hour..... minute..... M.

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

Immediate cause of death.....

Due to.....

Due to.....

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

Major findings:
Of operations.....

Of autopsy.....

Duration

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..... (M. D. or other).....

Address..... Date signed.....

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