. No. 2
9-4-41
17-39
X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

9724

State File No.

FILED APR 14 1943

Registration District No. 2

Primary Registration District No. 1000

Registrar's No. 329

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: Mo St Hosp. No 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr 1 mo, 24 days
(Specify whether years, months or days)

In this community 1 yr 1 mo 14 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

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

(d) Street No. R 7 D Little Blue Mo.
(If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME William L. Wright

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex M

5. Color or race White

6. (a) Single, widowed, married, divorced 3 Divorced

6. (b) Name of husband or wife

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

7. Birth date of deceased May (Month) 14 (Day) 1900 (Year)

8. AGE: Years 42 Months 9 Days 23 If less than one day — hr. — min.

9. Birthplace Lee's Summit (City, town, or county) Mo (State or foreign country)

10. Usual occupation Trucker

11. Industry or business Auto Trucking

MOTHER FATHER

12. Name Lewis Wright

13. Birthplace No record (City, town, or county) — (State or foreign country)

14. Maiden name Betty Wanburn

15. Birthplace No record (City, town, or county) — (State or foreign country)

16. (a) Informant Records Mo St Hosp No 2

(b) Address St Joseph, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-7-43 (Month) (Day) (Year)

(c) Place: burial or cremation Lee Summit Mo.

18. (a) Signature of funeral director Kleman & Son Inc

(b) Address 1946 Cottage St Jos Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1943 hour 1 minute 50 A. M.

21. I hereby certify that I attended the deceased from January 10, 1943 to March 7, 1943 that I last saw him alive on March 5, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Bronchopneumonia	5 days
Due to Organism undetermined	
Due to	
Other conditions Psychosis Delirium (Include pregnancy within 3 months of death) Tumor	3 yrs

Major findings:
Of operations
Of autopsy

107

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. G. Rowe (M. D. ~~coroner~~)

Address Mo. St Hosp No 2 Date signed 3-7-43 St. Joseph, Mo.

1235 (Licensed Embalmer's Statement on Reverse Side)

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 Robert L. Yaple

Licensed Embalmer No. 3308

P. O. Address St Joseph, Mo.

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

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

V. S. No. 2B
0M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 9724

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 329

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: State Hospt #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days) In this community .....

2. USUAL RESIDENCE OF DEACESED:
(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 .....

3. (a) PRINT FULL NAME Wm L. 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 D
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased May (Month) 14 (Day) 1900 (Year)
8. AGE: Years 42 Months 9 Days 2 If less than one day hr. ..... min.
9. Birthplace Mo (City, town, or county) (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER 12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER 14. Maiden name .....
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) 3-7-43 (Date received local registrar) (b) Rose Hergoz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March 7 year 1943 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.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

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 .....

SUPPLEMENTARY