

JUN 7 1943
Registration District No. 149

Primary Registration District No. 1002

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

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:
Home 6240 E 15th Terr.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community **55 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **6240 East 15th Terr.**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **William Ben Wright**

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

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

6. (b) Name of husband or wife **Lucy Wright** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **May 15th 1868**
(Month) (Day) (Year)

8. AGE: Years **74** Months **11** Days **15/6** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Carpenter**

11. Industry or business **none**

MOTHER FATHER { 12. Name **Joseph Wright**

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

14. Maiden name **Mary Coyle**

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

16. (a) Informant **Mrs. Lucy Wright**

(b) Address **6240 East 15th, Terr.**

17. (a) **Burial** (b) Date thereof **5/3/43**
(Place of burial or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Oak Grove Mo.**

18. (a) Signature of funeral director **Rose & Henderson**

(b) Address **Kansas City, Mo**

19. (a) **5-3-43** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **1st**
year **1943** hour **6** minute **35** M.

21. I hereby certify that I attended the deceased from **Jan. 1943**
19____ to **May 1 1943**
that I last saw him alive on **5/1/43**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial insufficiency (decompensation about) 6 mo.**

Due to **Associated with Atrial fibrillation 3 mo.**

Other conditions (Include pregnancy within 3 months of death) **92 L^r**

PHYSICIAN
Major findings: _____
Of operations _____
Of autopsy **none**
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 **2**

23. Signature **Olaf Callenbach**
Address **6047 E 15th** Date signed **5/3/43**

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: *John C. Camp*
Licensed Embalmer No. *29555*
P.O. Address *17 C. 7th*

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.**