

FILED FEB 14 1944

State File No. \_\_\_\_\_

Registration District No. 118

Primary Registration District No. 5796

Registrar's No. 10

1. PLACE OF DEATH:

(a) County Mercer  
(b) City or town Washington  
(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 47 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Mercer  
(c) City or town Rural Washington  
(If outside city or town limits, write "RURAL")  
(d) Street No. S. Of Princeton, Mo.  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Lucinda M. Wright

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

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

6. (b) Name of husband or wife Elijah Wright 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 28 1860  
(Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 22 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House Wife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Charles Lusk  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Lucinda Mix  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Wright

(b) Address Lucerne, Mo.

17. (a) Burial (b) Date thereof 1-21-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Princeton

18. (a) Signature of funeral director Merlin Funeral Home

(b) Address Princeton, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20  
year 1944 hour 8 minute 30 A.M.

21. I hereby certify that I attended the deceased from Jan 5  
1944, to Jan 20, 1944  
that I last saw him alive on Jan 20, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Thrombosis Duration 15 days

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: gfa  
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) (c) Means of injury g

23. Signature Byron Z. Cystell (M. D. or other) D.O.  
Address Princeton, Mo. Date signed 1-21-44

1561

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

**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. Ivan Martin*

1 Licensed Embalmer No.....

*3760*

P. O. Address.....

*Princeton, 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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Feb.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
 (a) County Merces  
 (b) City or town Rural  
(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 47 hr years, months or days)

**3. (a) PRINT FULL NAME** Lucinda M. Wright  
 3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced W  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased April 28 (Month) (Day) (Year)

8. AGE: Years 83 Months 8 Days 30 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, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) 1-21-44 (b) Gwen Martin (Date received local registrar) (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 Jan day 30 year 1944 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)

**PHYSICIAN**  
 Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
 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 \_\_\_\_\_

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

SUPPLEMENTARY

3585