

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

FILED JUN 22 1944

Registration District No. _____

Primary Registration District No. 1002

Registrar's No. _____

2474

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 25 days
(Specify whether
In this community unknown
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. Fox Hotel 598 Main
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME John Wright

3. (b) If veteran, name war 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 Nov. 7 1882
(Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 25 If less than one day _____ hr. _____ min.

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

10. Usual occupation No record

11. Industry or business No record

MOTHER FATHER { 12. Name John L. Wright
13. Birthplace Scotland
(City, town, or county) (State or foreign country)
14. Maiden name Katherine Douglas
15. Birthplace Ireland
(City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K. C. General Hospital No.

17. (a) Burial (b) Date thereof 6-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Under

18. (a) Signature of funeral director Wm. A. Bohannon

(b) Address City, Missouri

19. (a) 6-10-44 (b) T. E. Brown
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 2
year 1944 hour 9 minute _____ P. M.

21. I hereby certify that I attended the deceased from May 8 1944 to June 2 1944,
that I last saw him alive on June 2 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of lung Duration _____

Due to far advanced fibro caseous pulmonary tuberculosis

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

Major findings: Of operations 13 & 1 Of autopsy None PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(c) 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? _____

23. Signature A. E. Gosker (M. D. or other) MD
Address Med. Dir. Gen'l Hosp. Date signed 6-3-44

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.....

Licensed Embalmer No.....

P. O. Address.....

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.