

FILED DEC 9 1944
Registration District No.

Primary Registration District No. 3075

Registrar's No. 103

1. PLACE OF DEATH:

(a) County HOWELL
(b) City or town WEST PLAINS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
CHRISTA HOGAN HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 DAYS
(Specify whether years, months or days)
In this community 29 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HOWELL 46
(c) City or town "RURAL" WEST PLAINS
(If outside city or town limits, write "RURAL")
(d) Street No. LEBO RT.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME WILLIAM HENRY WRIGHT
3. (b) If veteran, name war. No. 3. (c) Social Security No.

20. DATE OF DEATH: Month November day 11
year 1944 hour 11 minute 45P M.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced. WIDOWED
6. (b) Name of husband or wife NANCY LAVINA WRIGHT
6. (c) Age of husband or wife if alive. years
7. Birth date of deceased AUGUST 31, 1869
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from October 31 1944 to November 11 1944
that I last saw him alive on November 11 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Cerebral Hemorrhage
Due to Chronic Sclerosis

8. AGE: Years 75 Months 2 Days 10
If less than one day hr. min.

Other conditions Fracture left femur caused by findings of operations
Due to celestial marriage

9. Birthplace SCOTLAND CO., MISSOURI
(City, town, or county) (State or foreign country)
10. Usual occupation FARMER

PHYSICIAN
Underline the cause to which death should be charged statistically.
Cerebral Hemorrhage

11. Industry or business FATHER
12. Name LEVI ARTHUR WRIGHT
13. Birthplace ENGLAND
(City, town, or county) (State or foreign country)
14. Maiden name M. ALISTER
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ADDITIONAL SUPPLEMENTARY INFORMATION RECEIVED
(b) Date of occurrence.
(c) Where did injury occur? RECEIVED (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

16. (a) Informant MRS. BURL FRANCIS
(b) Address WEST PLAINS, MO.
17. (a) BURIAL (b) Date thereof NOV 13, 1944
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation. WEST PLAINS, MO.

18. (a) Signature of funeral director Walter Thompson (Specify type of place) While at work? OV
(b) Address WEST PLAINS, MO. (c) Means of injury OV
19. (a) 11-25-44 (b) Walter Thompson
(Date received local registrar) (Registrar's signature)
Address West Plains, Mo.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 5,

District File Number 124610

Date Filed 12-8-44

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 _____

Hal Thomburg

Licensed Embalmer No. 3408

P. O. Address West Plains, 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.

Registration District No. 141

Primary Registration District No. 3025

Registrar's No. 103

1. PLACE OF DEATH:

(a) County Haskell
(b) City or town West Plains
(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 _____ (years, months or days)

3. (a) PRINT FULL NAME Wm Henry 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. w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ year

7. Birth date of deceased Aug 31 (Month) (Day) (Year)

8. AGE: Years 28 Months 2 Days 0 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (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 _____ Day _____ Year 1944 minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ that I saw him _____ alive on _____ 19____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to fall while climbing

the fence around

Due to fall Oct 31 - see

Causing fracture

Major findings left femur

Of operations _____

Of autopsy 1860/10

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? _____

23. Signature W. H. ... (Specify type of place) (e) Means of injury _____
Address 1022 17th St

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

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

Underline the cause to which death should be charged statistically.

37905