

FILED MAY 1 1945
2 3 3

Registration District No. 233

Primary Registration District No. 4348

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Wellsdale mo
(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 Milton Cotton Wright

3. (b) Veteran, From 3. (c) Social Security No. _____

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

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

7. Birth date of deceased June 17- 1905
(Month) (Day) (Year)

8. AGE: Years 39 Months 9 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name Leo Thomas Wright

13. Birthplace Woodville mo
(City, town, or county) (State or foreign country)

14. Maiden name Black

15. Birthplace Bloomfield Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nancy Whiting

(b) Address Wellsdale mo

17. (a) Burial (b) Date thereof 3-27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial Wellsdale mo

18. (a) Signature of funeral director Wellsdale mo

(b) Address Wellsdale mo

19. (a) April 6- 45 (b) Mrs. Virgie Norton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Wellsdale mo 105
(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 March day 25th
year 1945 hour 4 minute 10 A. M.

21. I hereby certify that I attended the deceased from 3/25/45
that I last saw him alive on 3/25/45 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor Duration 6 yrs

Due to _____

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy 57d

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) _____
Means of injury _____

23. Signature [Signature] (M. D. or other) _____

Address Wellsdale mo Date signed 3/27/45

MOTHER FATHER

1045

MAY 8 1945

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 Self

Registered Apprentice No. F

working under my personal supervision.

Signed

A. B. Wells

Licensed Embalmer No. 1588

P.O. Address Wellsville 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. 223 Primary Registration District No. 4348

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Wellsburg
(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 Milton C. 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 _____

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

7. Birth date of deceased June 17 1925
(Month) (Day) (Year)

8. AGE: Years 39 Months 9 Days _____ If less than one day, _____ min.

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

10. Usual occupation Tray 13 years

11. Industry or business Household Disinfectant

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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 May Day 25 Year 1965 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 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)

Major findings: Of operations _____

Of autopsy _____

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 _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MISSOURI SUPPLEMENT

MOTHER FATHER

MAR 11 1945

JUN 5 1945

14057