

S. No. 2
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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED SEP 25 1945
Registration District No. 199

Primary Registration District No. 1002

Registrar's No. 3834

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:
2540 Euclid
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community About 30 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Phillip J. Wright

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 2 5. Color or race Col

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lula Wright

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased July 30 1887
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

58 1 12 hr. min.

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

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Charlie Wright

13. Birthplace Mo. M
(City, town, or county) (State or foreign country)

14. Maiden name Nancy Chase

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

16. (a) Informant Lula Wright

(b) Address 2540 Euclid

17. (a) removed (b) Date thereof 9/15/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malta Bend, Mo.

18. (a) Signature of funeral director Walter J. Groves

(b) Address 1729 Lydia

19. (a) 9-15-45 (b) Heraldine Holmes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street 2540 Euclid 8
(If rural, give location) 0

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 12
year 1945 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from Sept - 6 - 1945 to Sept 11 1945
that I last saw him alive on Sept - 11 1945
and that death occurred on the date and hour stated above.

Immediate cause of death

Mitral Insufficiency 6 days

Due to Endo-Carditis 6 mos.

Due to Chronic Nephritis 2 yrs.

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

Major findings:
Of operations 13/15

Of autopsy _____

Duration

6 days

6 mos.

2 yrs.

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)

(e) Means of injury _____

23. Signature H. Williams (M. D. or other)

Address 2636 Broadway Date signed 9/14/45

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

J. R. Williams

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.