

FILED FEB 11 1946

Registration District No. _____

Primary Registration District No. 1000

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 Month-Hosp't
(Specify whether years, months or days)
 In this community 19 Years.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan
 (c) City or town St. Joseph
(If outside city or town limits, write "RURAL")
 (d) Street No. 503 No. 11th. St.
(If rural, give location)
 (e) Citizen of foreign country? No. (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Margaret Wright

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

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

6. (b) Name of husband or wife Elmer A. Wright
 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased February 12 1889
(Month) (Day) (Year)

8. AGE: Years 56 Months 11 Days 15
 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business None

12. Name Wm. Dan Brohman

13. Birthplace Unknown Canadian
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Faling

15. Birthplace Unknown Canadian
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Elmer Wright

(b) Address 503 No. 11th. St.

17. (a) Burial (b) Date thereof Jan. 29, 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cemetery

18. (a) Signature of funeral director Norman W. Stouffer
 (b) Address 1802 Union St., St. Joseph, Mo.

19. (a) Jan. 30, 1946 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 27
 year 1946 hour 6 minute 00 A.M.

21. I hereby certify that I attended the deceased from 12-29-45 to 1-27-46
 that I last saw her alive on 1-26 and that death occurred on the date and hour stated above.

Immediate cause of death Fracture greater trochanter right femur
 Duration 12-29-45

Due to _____
 Due to _____
 Other conditions Pulmonary embolus 1-27-46
(Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy Pulmonary embolus
 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) Accident
 (b) Date of occurrence 12-29-45
 (c) Where did injury occur? St. Joseph Buchanan Mo
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public street - slipped on ice
(Specify type of place) (e) Means of injury Fell

23. Signature [Signature] (M. D. or other)
 Address St. Joseph Mo Date signed 1-28-46

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

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JUL 01 1945

FEB 18 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 by _____

_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed Elmer Thomas

Licensed Embalmer No. 2640

P. O. Address St. Joseph 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.