

S. No. 2  
-12-45  
5-17-39  
PI X47070

DEPARTMENT OF COMMERCE  
BUREAU OF VITAL STATISTICS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26397

State File No. \_\_\_\_\_

Registrar's No. 944

Registration District No. 42

Primary Registration District No. 5123

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town Rural Agency Twp. R.F.D. #1  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)  
In this community entire life  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Buchanan  
(c) City or town Agency Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. R.F.D. #1  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

William Wright

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. --

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 20  
year 1946 hour 04 minute 30 a.m.  
21. I hereby certify that I attended the deceased from 8-1-45  
\_\_\_\_\_ 19, to 8-19-46 19;  
that I last saw him alive on 8-19-46  
and that death occurred on the date and hour stated above.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Minnie Wright  
6. (c) Age of husband or wife if alive 72 years  
7. Birth date of deceased Nov. 13 1872  
(Month) (Day) (Year)

Immediate cause of death acute myocarditis  
Due to chronic myocarditis  
Duration 1 week  
3 years

8. AGE: Years 73 Months 9 Days 7  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Buchanan Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Sylvester Wright

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

14. Maiden name Temperance Sims

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

16. (a) Informant Mrs. Minnie Wright

(b) Address Agency Mo.

17. (a) Burial (b) Date thereof Aug 21-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Agency Cem.

18. (a) Signature of funeral director H. A. Bullins

(b) Address Agency Mo.

19. (a) Aug. 23 1946 (b) H. J. Mitchell  
(Date received local registrar) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 928  
Of autopsy \_\_\_\_\_  
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 2  
23. Signature B. M. Raper M.D. (M. D. or other)  
Address 12207 Remy Blvd Date signed 8-20-46

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

25243

54

767

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**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.....

*H. A. Sullins*

Licensed Embalmer No. *1738*

P. O. Address *Gower 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.**