

FILED FEB 17 1947 49

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

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

1. PLACE OF DEATH:

(a) County JACKSON  
(b) City or town K.C. MO.  
(c) Name of hospital or institution HOME 1327 Lydia  
(d) Length of stay: 12 YRS.  
In this community 12 YRS.

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County JACKSON  
(c) City or town KANSAS CITY MO  
(d) Street No. 1327 LYDIA APT 8 K.C. MO.  
(e) Citizen of foreign country? NO

3. (a) PRINT FULL NAME DELLA WRIGHT

3. (b) If veteran, name war NO 3. (c) Social Security No. 500-22-2736

4. Sex FE ♀ 5. Color or race NEGRO 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife DAVID WRIGHT 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased JUNE 22 1896

8. AGE: Years 50 Months 8 Days 10 If less than one day hr. min.

9. Birthplace CARTHAGE MO

10. Usual occupation UNEMPLOYED

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

12. Name JAMES TRIPLETT

13. Birthplace DONT KNOW

14. Maiden name MARY WILSON

15. Birthplace DONT KNOW

16. (a) Informant JOSIE IRVING

(b) Address 1906 E. 11th K.C. MO.

17. (a) Burial (b) Date thereof 2-6-47

(c) Place: burial or cremation Blue Ridge Rebur

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 2 year 1947 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw Deputy Coroner alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy  
Due to hypertensive heart disease

Other conditions (include pregnancy within 3 months of death) 93D

Major findings: Of operations \_\_\_\_\_ Of autopsy no permit

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? \_\_\_\_\_  
(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 Apoplexy

23. Signature Amelias (M. D. or other) \_\_\_\_\_ Address 2636 Brooklyn Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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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 *x Lawrence A. Jones*

Licensed Embalmer No. *4439*

P. O. Address *2500 Park (N.C.M)*

**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.