—1/47
5-17-39

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

National Office of Vital Statistics
FILED NOV 29 1947

STANDARD CERTIFICATE OF DEATH

State File No. 65522

Registration District No. 149 — Primary Registration District No. 102 — Registrar's No. 4875

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: General Hospital No. 1 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5½ hrs. (Specify whether years, months or days)
In this community: unknown

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 No.: 709 Washington 8
(If rural, give location)
(e) Citizen of foreign country? unknown (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: William Wright
3. (b) If veteran, name war: no
3. (c) Social Security No.: none
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: unk. 4
6. (b) Name of husband or wife: unknown
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: unknown (Month) (Day) (Year)

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

9. Birthplace: unknown 7 (City, town, or county) (State or foreign country)
10. Usual occupation: none
11. Industry or business: 7
MOTHER
12. Name: 7
13. Birthplace: unknown (City, town, or county) (State or foreign country)
FATHER
14. Maiden name: 7
15. Birthplace: 7 (City, town, or county) (State or foreign country)
16. (a) Informant: MRS LEE TAYLOR
(b) Address: 1460 So. CLAYTON DENVER COLO.
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 11-19-47 (Month) (Day) (Year)
(c) Place: burial or cremation: MT MORIAH
18. (a) Signature of funeral director: STINETT McCLURE
(b) Address: 3285 GILLHAM PLAZA.
19. (a) 11-20-47 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 17 year 1947 hour 4 minute 35 P. M.
21. I hereby certify that I attended the deceased from 11-17 1947 to 11-17 1947 that I last saw him alive on 11-17 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebral thrombosis-Pulmonary infarction — Duration
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operations: 8316
Of autopsy: See above

PHYSICIAN — Underline the cause of 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? (Specify type of place)
While at work? (e) Means of injury: 0
23. Signature: [illegible] (M. D. or other) M.D.
Address: Med. Dir. Gen'l Hosp. Date signed: 11-18-47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

Dr. Ridings

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 Robert H Reed

Licensed Embalmer No. 3745

P. O. Address K. C. 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.