

S. No. 2
FORM-5-43
Rev. 5-17-39
I X36871

FILED JUN 1 1948
Registration District No. **149**

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 Kennett
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Trinity Lutheran Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5-17-48 to 5-18-48
(Specify whether years, months or days)

In this community see above

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Lee Summit
(If outside city or town limits, write "RURAL")

(d) Street No. B-49 Lake Katowana
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Baby Hope Wright

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May-17-48
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 18
year 1948 hour 2 minute 45 A.M.

21. I hereby certify that I attended the deceased from May 17 1948 to May 18 1948
that I last saw her alive on May 17 1948
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Prematurity
Estimated 6 1/2 - 7 months

Due to Caesarian Section because

Due to Central Place
Maeva E. Kuenenhoop (mother)

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

Duration _____

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>0</u>	<u>9 hr. 16 min.</u>

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

10. Usual occupation None

11. Industry or business _____

Major findings:
Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

12. Name Theodore A Wright

13. Birthplace New York City, N.Y.
(City, town, or county) (State or foreign country)

14. Maiden name Hope Eugenia Carlson

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

16. (a) Informant Mr. Theodore A Wright

(b) Address B-49 Lake Katowana

17. (a) Burial (b) Date thereof 5-19-48
(City, town, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Fragman Mortuary

(b) Address Kennett, Missouri

19. (a) 5-19-48 (b) Sheraldine Holmes
(Date received local registrar) (Registrar's signature)

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)

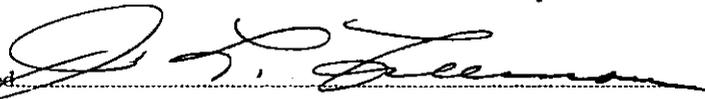
Means of injury _____

23. Signature Eugene J. Ferguson (M. D. or other)

Address 933 Park Bldg Date signed 5-18-48

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..... 1939

P. O. Address..... F. O. 510

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.