

FILED SEP 27 1948

Registration District No. **12**

Primary Registration District No. **1000**

Registrar's No. **989**

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:
1829 Jones Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **not** (Specify whether
 years, months or days) **27 years.**

3. (a) PRINT FULL NAME **Maude Jane 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 **Widow**

6. (b) Name of husband or wife **J. E. Wright** 6. (c) Age of husband or wife if alive **years**

7. Birth date of deceased **August 14 1880**
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
 68 **0** **28** hr. min.

9. Birthplace **Cosby Missouri**
 (City, town, or county) (State or foreign country)

10. Usual occupation **At home**

11. Industry or business

12. Name **Joseph Smith**

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

14. Maiden name **Alice Orron**

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

16. (a) Informant **Mrs. Loretta Giles**

(b) Address **1829 Jones St., St. Joseph, Mo.**

17. (a) **Burial** (b) Date thereof **Sept. 14, 1948**
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Walter Meierhoff**

(b) Address **1946 Colhoun St., St. Joseph, Mo.**

19. (a) **9-20-48** (b) **G. G. Jenkins**
 (Date received local registrar) (Registrar's signature)

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. **1829 Jones Street**
 (If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **September** day **12th**
 year **1948** hour **12** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **Sept. 1**
 19**48** to **Sept. 12, 1948**
 that I last saw her alive on **Sept. 11, 1948**
 and that death occurred on the date and hour stated above.

Immediate cause of death
Coronary occlusion 6 hrs.
Chronic myocarditis 2 yrs.

Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations
 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:
 (c) 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) (c) Means of injury
 23. Signature **W. M. Teathaler** (M. D. or other)
 Address **St. Joseph, Mo.** Date signed **9/17/48**

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

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

Albert C. Harrington

Licensed Embalmer No. 3258 Missouri

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.