

S. No. 2  
1-8-43  
5-17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33634

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

FILED NOV 1 1948

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

Primary Registration District No. 3048

Registrar's No. 248

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Manlyville  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 22 hrs  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Taylor 999  
(c) City or town Washington Township 13  
(If outside city or town limits, write "RURAL") 2  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME David Allan Wright

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced -

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Oct 13 - 1948  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
0 0 1 1 hr. min.

9. Birthplace Washington Township Grant, Iowa  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 12. Name Sam Wright  
13. Birthplace Auburn Nebr. 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Rosa Sanders  
15. Birthplace Auburn Nebr. 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Wright  
(b) Address Front St, Iowa  
17. (a) Burial (b) Date thereof Oct 15 - 1948  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Auburn, Nebr.

18. (a) Signature of funeral director Frank W. ...  
(b) Address Bedford, Iowa  
19. (a) 98 (b) Bess Holt  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 14 year 1948 hour 8 minute A M.

21. I hereby certify that I attended the deceased from 10-13 1948 to 10-14 1948

that I last saw him alive on 10-13 1948 and that death occurred on the date and hour stated above.

Immediate cause of death Premature labor Born when mother was 6 mo. Duration 1 day  
Due to Pregnancy and weighed only 1 lb 7 oz

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 159 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) (c) Means of injury \_\_\_\_\_

23. Signature J. J. ... (M. D. or other) MD  
Address Bedford, Iowa Date signed 10-14-48

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

DISTRICT HEALTH OFFICE  
Cameron, Md.

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.....

*Myself -*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *Frank Wetmore Jr*

Licensed Embalmer No. *7519*

P. O. Address *Bedford, Iowa*

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.