

FILED APR 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11313

State File No. ....

BIRTH NO. .... REG. DIST. NO. 360 PRIMARY REG. DIST. NO. 6225 Registrar's No. 67

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Barton</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Liberal Wash. Sub. 1 mo 7 day</u>		c. LENGTH OF STAY (in this place) <u>1 mo 7 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Liberal / R.R. Arcadia Kan</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital #38</u>			d. STREET ADDRESS (If rural, give location) <u>R.R. Arcadia Kan</u>		

3. NAME OF DECEASED (Type or Print) a. (First) <u>ALICE</u> b. (Middle) <u>WRIGHT</u> c. (Last) <u>WRIGHT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>3-30-49</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 15, 1865</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 1 HRS. Hours <u>-</u> Mins. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kans</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
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13a. FATHER'S NAME <u>Benjamin Hill</u>		13b. MOTHER'S MAIDEN NAME <u>Nancy Ann Coker</u>		14. NAME OF HUSBAND OR WIFE <u>John J. Wright</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hospital records Dept</u> ADDRESS <u>_____</u>	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <u>Senile deterioration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) <u>✓</u>  DUE TO (c) <u>✓</u>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>794X</u>					

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from 2-7-1949 to 3-30-1949 that I last saw the deceased alive on 3-30-1949 and that death occurred at 2:25 pm., from the causes and on the date stated above.

23a. SIGNATURE <u>R. G. Hall M.D.</u> (Degree or title)		23b. ADDRESS <u>Thurston Mo</u>		23c. DATE SIGNED <u>3-30-49</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>April 2, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Parson Kansas</u>	
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DATE REC'D BY LOCAL REG. <u>April 1-49</u>		REGISTRAR'S SIGNATURE <u>Walter H. Vancay</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>331 Clarence W. Childs</u> ADDRESS <u>Lamat Mo</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1088

*So. Calif.  
Mrs. J. [unclear]  
204 So. [unclear]*

RECEIVED

District Health Officer No. 71

District File Number 3-49-355

Date Filed 4-11-49

Aug 17 1950

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~~ \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Clarence W. Chiles*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 3473

P. O. Address Lamar 760

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.