

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27733

FILED AUG 18 1949

BIRTH NO. _____		REG. DIST. NO. 299		PRIMARY REG. DIST. NO. 300-6		Registrar's No. 176	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)			
a. COUNTY Randolph		b. CITY (If outside corporate limits, write RURAL and give township) Moberly		a. STATE Missouri		b. COUNTY Randolph	
c. LENGTH OF STAY (in this place)		d. FULL NAME OF HOSPITAL OR INSTITUTION 421 Monroe 1		c. CITY (If outside corporate limits, write RURAL and give township) Moberly		d. STREET ADDRESS (If rural, give location) 421 Monroe	
3. NAME OF DECEASED (Type or Print) Boyd Wright			4. DATE OF DEATH Aug 7 1949				
a. (First)		b. (Middle)		c. (Last)			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 13 1875	
9. AGE (In years last birthday) 74		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mo	
10a.		10b.		11.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Leland Wright			13b. MOTHER'S MAIDEN NAME Euphie Harden Ivie			14. NAME OF HUSBAND OR WIFE Ivie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME Mrs Ivie Wright	
18. CAUSE OF DEATH			MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
Enter only one cause per line for (a), (b), and (c)			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy				5 da
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocarditis ch				
			DUE TO (c)				
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				334X
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
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?			
22. I hereby certify that I attended the deceased from July 20, 1949, to Aug 7, 1949, that I last saw the deceased alive on 8-7-49, and that death occurred at 3:30 P.M., from the causes and on the date stated above.							
23a. SIGNATURE H.G. Guffelmo MD (Degree or title)				23b. ADDRESS Moberly Mo		23c. DATE SIGNED 8-8-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-9-49		24c. NAME OF CEMETERY OR CREMATORY Oakland		24d. LOCATION (City, town, or county) (State) Moberly, Mo	
DATE REC'D BY LOCAL REG. 8-9-49		REGISTRAR'S SIGNATURE Leah Sullivan Love		P 264		25. FUNERAL DIRECTOR'S SIGNATURE Mahaw Anderson Moberly Mo	

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

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RECEIVED AUG 15 1949
District Health Officer No. 10
District File Number 8-49-1418
Date Filed AUG 16 1949

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

Frank B DeWitt

Licensed Embalmer No. 3021

P. O. Address Moberly Mo

Signed.....
Student Embalmer

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.