

FILED MAR 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 4246

BIRTH NO. _____ REG. DIST. NO. 70 PRIMARY REG. DIST. NO. 5284 Registrar's No. 10

230

1. PLACE OF DEATH a. COUNTY <i>Clark</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Clark</i>	
b. CITY (If outside corporate limits, write full name and give township) <i>Alexandria</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Alexandria 0230</i>	
c. LENGTH OF STAY (in this place) <i>30 yrs.</i>		d. STREET ADDRESS (If rural, give location) <i>0</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) a. (First) <i>VOLNEY</i>		b. (Middle) <i>J. WRIGHT</i>		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <i>Feb. 6 1950</i>							
5. SEX <i>male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>widowed</i>		8. DATE OF BIRTH <i>Mar. 22 - 1881</i>		9. AGE (In years last birthday) <i>68</i>		IF UNDER 1 YEAR Months <i>10</i> Days <i>14</i>		IF UNDER 1 HR. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>merchant</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Luray, Missouri</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13a. FATHER'S NAME <i>Joseph Wright</i>				13b. MOTHER'S MAIDEN NAME <i>unknown</i>			14. NAME OF HUSBAND OR WIFE <i>Lena M. Wright</i>						

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 ADDRESS <i>Lloyd Wright - Alexandria Mo</i>			
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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, asphemia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>CORONARY THROMBOSIS</i>						INTERVAL BETWEEN ONSET AND DEATH	
		ANTECEDENT CAUSES: Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						<i>4/301</i>	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 *1-4-42*, 19*42*, to *2-6*, 19*50*, that I last saw the deceased alive on *2-6*, 19*50*, and that death occurred at *10 p.m.*, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>A. B. Shannon M.D.</i>		23b. ADDRESS <i>Kahoka Mo</i>		23c. DATE SIGNED <i>2-7-50</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>Feb. 9, 1950</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Kahoka Cem.</i>		24d. LOCATION (City, town, or county) (State) <i>Kahoka, Mo.</i>	
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DATE REC'D BY LOCAL REG. <i>2-1-50</i>		REGISTRAR'S SIGNATURE <i>A. B. Shannon</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Witness Und. Kahoka</i>	
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WRITE MAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 6 1950

JUN 25 1951

SEP 17 1951

RECEIVED MAR 2 1950
District Health Officer No.
District File Number 2-52-
MAR 2 1950
Date Filed

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.....
Student Embalmer

Signed *Olin L. Sutting*

Licensed Embalmer No. *2965*

P. O. Address *Luraymo*

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.