

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12174**

FILED MAY 15 1952

BIRTH NO. _____ REG. DIST. NO. 43 PRIMARY REG. DIST. NO. 3007 Registrar's No. 218

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Ark. b. COUNTY Clay	
b. CITY (If outside corporate limits, write RURAL and give township) Poplar Bluff		c. CITY (If outside corporate limits, write RURAL and give township) Corning, Mo.	
c. LENGTH OF STAY (in this place) 3 wks.		d. STREET ADDRESS (If rural, give location) Gen. Del.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Doctors Hospital			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) WILLIAM	b. (Middle) FRANKLIN	c. (Last) WRIGHT	(Month) April	(Day) 22	(Year) 1952
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 12-13-1891	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR: Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired barber		10b. KIND OF BUSINESS OR INDUSTRY Barber	11. BIRTHPLACE (State or foreign country) Supply, Ark.	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME G. W. Wright	13b. MOTHER'S MAIDEN NAME Nancy E. Jones	14. NAME OF HUSBAND OR WIFE Ollie Wright (Wife)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Ollie Wright, Corning, Ark.

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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) cardiac failure		
	DUE TO (c) carcinomatosis very extensive		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. extensive			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION carcinomatosis extensive (metastatic mucous)		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) Corning, Mo. (STATE) Mo.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 4-1-1952 to 4-22-1952, that I last saw the deceased alive on 4-22-1952, and that death occurred at 4:40 P.M., from the cause and on the date stated above.

23a. SIGNATURE (Degree or title) **W. H. Markel M.D.** 23b. ADDRESS **Poplar Bluff, Mo. 4-30-52** 23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-24-52	24c. NAME OF CEMETERY OR CREMATORY Corning Cemetery	24d. LOCATION (City, town, or county) (State) Corning, Ark.
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DATE REC'D BY LOCAL REG. 5-10-52	REGISTRAR'S SIGNATURE Wm. H. Johnson	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Mortuary, Corning, Ark.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED
MAY 13 1952
BUTLER CO. HEALTH CENTER
FILE No. 552-051

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.

Student
Student Embalmer

Signed

Leslie D. Russell

Licensed Embalmer No.

3855

P. O. Address

Corning, Ark.

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.