

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10237**

FILED MAR 31 1953

BIRTH NO.		REG. DIST. NO. 150	PRIMARY REG. DIST. NO. 5574	Registrar's No. 74
1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY Morgan		
b. CITY OR TOWN Van Buren Twp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Stover Mo Rural 0710		
d. FULL NAME OF HOSPITAL OR INSTITUTION 450 Hi Way East of Stover		d. STREET ADDRESS (If rural, give location) 4 mi So of Stover on #135		
3. NAME OF DECEASED (Type or Print) a. (First) Beulah b. (Middle) Mabel c. (Last) Wright		4. DATE OF DEATH (Month) (Day) (Year) 3-12-53		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-17-1903	9. AGE (In years last birthday) 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY wife Home		11. BIRTHPLACE (State or foreign country) Kansas
12. COUNTRY OF WHAT COUNTRY? USA				
13a. FATHER'S NAME Charles Mc Ginnis		13b. MOTHER'S MAIDEN NAME Bertha Sewier		14. NAME OF HUSBAND OR WIFE Dayton Wright
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.		17. INFORMANT'S SIGNATURE OR NAME Leoine Ginnis ADDRESS Kansas City Kan
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull Fractures ANTECEDENT CAUSES both legs contusions chest Morbid 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.		INTERVAL BETWEEN ONSET AND DEATH		
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) Accident	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Jackson Mo		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 3-12-53 4:00 A.M.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? Two Car Collisions		
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.				
23a. SIGNATURE Mrs. M. A. Owens (Degree or title) 3		23b. ADDRESS 1034 Pacific Bldg.		23c. DATE SIGNED 3-12-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-12-53	24c. NAME OF CEMETERY OR CREMATORY Chapel Hill	24d. LOCATION (City, town, or county) (State) Kansas City Kan	
DATE REC'D BY LOCAL REG. 3/12/53	REGISTRAR'S SIGNATURE W B Langford	25. FUNERAL DIRECTOR'S SIGNATURE Jos A Butler ADDRESS 483 1/2 S. 9th St Kansas City Kan		

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

Beulah Wright

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AUG 10 1953

AUG 10 1953

OCT 8

1953

APR 16 1953

AUG 10 1953

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 _____

H. Blaney Joul

Licensed Embalmer No. 3833

P. O. Address Leis Summit

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.