

FILED MAY 2 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 11117

BIRTH NO. _____		REG. DIST. NO. 42		PRIMARY REG. DIST. NO. 1000		Registrar's No. 430		
1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph		c. LENGTH OF STAY (In this place) 7 yrs 3 mos 4 days		c. CITY OR TOWN Kansas City		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital #2				f. STREET ADDRESS (If rural, give location) 1319 East 14th Street 3168/1				
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) PHILLIP c. (Last) WRIGHT			4. DATE OF DEATH (Month) (Day) (Year) APRIL 18, 1955					
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married		8. DATE OF BIRTH Dec 11, 1904		
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Laborer			10b. KIND OF BUSINESS OR INDUSTRY Section		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Unknown			13b. MOTHER'S MAIDEN NAME Mary Steven			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 499-07-2025		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Albert Wright, 1319 E. 14th St., K.C., Mo.				
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) Stroke on right side of body ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Syphilis DUE TO (c) Brain deterioration II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary thrombosis					INTERVAL BETWEEN ONSET AND DEATH 1 mo. 7 yrs + chronic suddenly	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Brain injury and pulmonary thrombosis 020X					20. AUTOPSY? YES <input checked="" 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 April 17, 1955, to April 18, 1955, that I last saw the deceased alive on April 17, 1955, and that death occurred at 3:00a m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or Title) G.E. Gossime M.D.			23b. ADDRESS State Hospital #2, St. Jos., Mo.			23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE April 21, 1955		24c. NAME OF CEMETERY OR CREMATORY Nelson Cemetery		24d. LOCATION (City, town, or county) (State) Nelson, Saline, Missouri		
DATE REC'D BY LOCAL REG. April 26, 1955		REGISTRAR'S SIGNATURE Esther M. Allison 495		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS George A. Beer Marshall Mo				

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

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.....
Signature of Student Embalmer

→ Signed.....
George H. Green

Licensed Embalmer No. *47*

P. O. Address *Mercha*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.