

FILED APR 8 - 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11744**

BIRTH NO. _____		REG. DIST. NO. <b>324</b>		PRIMARY REG. DIST. NO. <b>3072</b>		Registrar's No. <b>60</b>		
1. PLACE OF DEATH a. COUNTY <b>Saline</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Saline</b>				
b. CITY OR TOWN <b>Marshall</b>		c. LENGTH OF STAY (in this place) <b>36 days</b>		c. CITY OR TOWN <b>Malta Bend</b>		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 <b>Fitzgibbon Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>Streets not numbered</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Sarah</b> b. (Middle) <b>Adams</b> c. (Last) <b>Wright</b>			4. DATE OF DEATH <b>April 5, 1957</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec. 10, 1879</b>		
9. AGE (In years last birthday) <b>77</b>		IF UNDER 1 YEAR Months <b>3</b> Days <b>25</b>		IF UNDER 12 HRS. Hours <b></b> Min. <b></b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Saline County, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>George D. Adams</b>			13b. MOTHER'S MAIDEN NAME <b>Anna Neff</b>			14. NAME OF HUSBAND OR WIFE <b>Harry C. Wright</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Harry C. Wright</b> ADDRESS <b>Malta Bend, Mo.</b>				
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Multiple Myeloma</b>  ANTECEDENT CAUSES  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? <b>2</b> 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) 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 <b>Jan</b> , 19 <b>57</b> , to <b>4-5</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4-5</b> , 19 <b>57</b> , and that death occurred at <b>11:49 p.m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>James A. Read MD</b> (Degree or title)				23b. ADDRESS <b>Marshall Mo</b>		23c. DATE SIGNED <b>4-7-57</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>3-8-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Malta Bend Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Malta Bend, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>4-6-57</b>		REGISTRAR'S SIGNATURE <b>Carl G. Read</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Campbell-Lewis</b> ADDRESS <b>Marshall, Mo.</b>				

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

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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.....

*James H. Lewis, Jr.*

Licensed Embalmer No. *4709*.....

P. O. Address *Marshall, M.*.....

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.