

THE DEPARTMENT OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41183

STATE FILE NUMBER

FILED DEC 11 1957

Registration District No. 217 Primary Registration District No. 4329 Registrar's No. 86

1. PLACE OF DEATH COUNTY <b>Mississippi</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Miss.</b>									
b. CITY: (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Wyatt</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Wyatt</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>P.O. Box 692</b>			Length of stay in 1b <b>15 yrs.</b>		d. STREET ADDRESS <b>P. O. Box 692</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Lena Wright</b>				First <b>Lena</b> Middle <b>Wright</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>30,</b> Year <b>1957</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 17, 1880</b>		9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (City and state or country) <b>Jackson, Miss.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Taft Jones</b>						14. MOTHER'S MAIDEN NAME <b>Carey Jones</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. -----		17. INFORMANT Address <b>Mrs. Viola Foster, Wyatt, Mo.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Metastatic carcinoma.</b> DUE TO (c) <b>Carcinoma of uterus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>7 months</b>			
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>													
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)			20f. CITY, TOWN, OR LOCATION			COUNTY		STATE		
21. I attended the deceased from <b>Dec 57</b> , to <b>Nov 157</b> and last saw her alive on <b>Nov 29/57</b> Death occurred at <b>11:45 A.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>[Signature]</i> (Degree or title)						22b. ADDRESS <b>Wyatt, Mo.</b>				22c. DATE SIGNED <b>12-4-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 4, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>				23d. LOCATION (City, town, or county) (State) <b>Charleston, Missouri</b>					
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS <b>Charleston, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>12-6-57</b>				26. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare, Public Services  
300-1-56  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

RECEIVED  
Miss. Co. Health Dep  
County File No.  
Date Filed 12-9-5

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 *Edward A. Puffin*.....

Licensed Embalmer No. 5022  
2501 Poplar  
P. O. Address Cairo, Ill.

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.