

t. Health,  
& Welfare  
s. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036159  
STATE FILE NUMBER

FILED NOV 3 1958 Registration District No. 133 Primary Registration District No. 4209 Registrar's No. 139

S. 300  
V. 1-57

1. PLACE OF DEATH a. COUNTY <b>Harrison</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Harrison</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Mt. Moriah</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Mt. Moriah</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>At home</b>		Length of stay in lb <b>All life</b>	041 <sup>d</sup> STREET ADDRESS (If outside, give location) <b>0</b> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Porter</b> Middle <b>Reid</b> Last <b>Wright</b>			4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>1958</b>			
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5. SEX <b>Male</b> <input type="radio"/>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="radio"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 3, 1913</b>	9. AGE (In years last birthday) <b>45</b>	10. FUNDER 1 YEAR Months <b>45</b> Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>General Farm</b>	11. BIRTHPLACE (City and state or country) <b>Trailcreek Twp. Harrison Co. Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Theodore Wright</b>	13b. MOTHER'S MAIDEN NAME <b>Alma Emry</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War Two</b>	16. SOCIAL SECURITY NO. <b>497-34-1144</b>	17. INFORMANT <b>Theodore Wright, Mt. Moriah, Mo.</b>
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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>Gunshot wound in right temple</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <b>976X</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>Patient shot self with 22 caliber rifle, bullet</b>
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20c. TIME OF INJURY Hour <b>5:45</b> a.m. Month <b>10</b> Day <b>27</b> Year <b>58</b>	<b>entering right temporal area</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>At home</b>	20f. CITY, TOWN, OR LOCATION <b>Mt. Moriah</b>	COUNTY <b>Harrison</b>	STATE <b>Mo</b>
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21. I attended the deceased from **About 5:45 A. M.** to **2** and last saw her alive on **D.O.**  
Death occurred at **About 5:45 A. M.** on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>G.H. Throop</b> (Degree or title) <b>D.O.</b>	22b. ADDRESS <b>Bethany, Missouri.</b>	22c. DATE SIGNED <b>10-28-58</b>
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23a. BURIAL CREMATION <b>Buried</b>	23b. DATE <b>Oct. 29, 1958.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lloyd Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>RFD Ridgeway, Mo.</b>
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24. FUNERAL DIRECTOR <b>[Signature]</b>	ADDRESS <b>Cainsville, Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>10-29-1958</b>	26. REGISTRAR'S SIGNATURE <b>Jella Maxey</b>
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(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

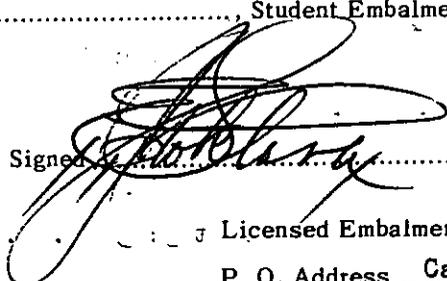
NOV 7 1958

DEC 9 1958

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 Eddie J. Stoklasa Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed  .....

Licensed Embalmer No. .... 3602

P. O. Address Cainsville, Mo.

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.