

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-001052
STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 62

300
-57

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield,		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital		Length of stay in lb 38 years	d. STREET ADDRESS (If outside, give location) 615 E. Loren
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Nelle McCanse Wright			4. DATE OF DEATH Month January Day 16 Year 1959		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1883	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 9 Days 23	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) In Home	10b. KIND OF BUSINESS OR INDUSTRY In Home	11. BIRTHPLACE (City and state or country) Mt. Vernon, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Emory M. Wright	13b. MOTHER'S MAIDEN NAME Sallie McCanse	14. NAME OF HUSBAND OR WIFE Single
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) None	16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT H. Garrett Wright	Address Springfield, Mo.
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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) Miocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arteriosclerotic heart disease	Unknown
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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 Springfield	COUNTY Greene	STATE Missouri
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21. I attended the deceased from 1950 to 1/16/59 and last saw her alive on 1/16/59 Death occurred at 8 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) L. Richard Webb, M.D.	22b. ADDRESS 609 Cherry, Springfield, Mo.	22c. DATE SIGNED 1/17/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Jan. 19, 1959	23c. NAME OF CEMETERY OR CREMATORY City	23d. LOCATION (City, town, or county) (State) Mt. Vernon, Missouri
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24. FUNERAL DIRECTOR Springfield	ADDRESS Springfield, Mo.	25. DATE RECD. BY LOCAL REG. 1-19-59	26. REGISTRAR'S SIGNATURE Effie S. Melton
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1, 2, 6

JUN 25 1959

JAN 26 1959

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 *Lewis G. Sharpe*

Licensed Embalmer No. *3802*

P. O. Address *Springfield*

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.