

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-004948

STATE FILE NUMBER

1959 MAR 2

Registration District No. 82

Primary Registration District No. 5319

Registrar's No. 26

5-300  
1-57

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

1. PLACE OF DEATH a. COUNTY <u>Cooper</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cooper</u>				
b. CITY OR TOWN <u>Otterville TWP</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Otterville #276</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>R.F.D #2</u>			Length of stay in 1b <u>22 yrs</u>		d. STREET ADDRESS (If outside, give location) <u>R.F.D #2</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Belle WRIGHT</u>				4. DATE OF DEATH Month Day Year <u>Feb. 22 1959</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 27 1906</u>		9. AGE (In years last birthday) <u>52</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTH PLACE (City and state or country) <u>Kansas City, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Claton E. Carter</u>			13b. MOTHER'S MAIDEN NAME <u>Leta Bell Heldebrand</u>			14. NAME OF HUSBAND OR WIFE <u>Harry Wright</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Harry Wright</u>			Address <u>RFD #2 Otterville</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
DUE TO (b) <u>Residual and Metastatic Carcinoma of Pelvis</u>							<u>3 mos</u>	
DUE TO (c) <u>Carcinoma of Cervix (Stage III)</u>							<u>17 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>171X</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year								
20d. INJURY OCCURRED WHILE AT <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 <u>25 Mar 1951</u> , to <u>22 Feb 1959</u> and last saw <u>her</u> alive on <u>21 Feb 1959</u>				Death occurred at <u>1:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Glenn A. Walker, D.O.</u>				22b. ADDRESS <u>Sedalia, Missouri</u>		22c. DATE SIGNED <u>2/23/59</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Crown Hill</u>		23d. LOCATION (City, town, or county) <u>Sedalia</u>		STATE <u>Mo</u>	
24. FUNERAL DIRECTOR <u>McLaughlin Bros Sedalia</u>			ADDRESS		25. DATE RECD. BY LOCAL REG. <u>2/24/59</u>		26. REGISTRAR'S SIGNATURE <u>De Hooper</u>	

MAR 6 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 *K.P.M. Lrary* .....

Licensed Embalmer No. *3153* .....

P. O. Address *Sedalia* .....

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.