

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-024283

FILED VS AUG 10 1959

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785

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		c. CITY OR TOWN <i>St. Joseph</i>	
Length of stay in 1b <i>52 years</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>5209 Pryor Ave.</i>		d. STREET ADDRESS (If outside, give location) <i>5209 Pryor Ave.</i>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Frank Robert Wright</i>			4. DATE OF DEATH <i>Aug. 7, 1959</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27, 1902</i>
9. AGE (last birthday) <i>57</i>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat Butcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Swift & Co.</i>	11. BIRTHPLACE (City and state or country) <i>Starberry, Mo.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13a. FATHER'S NAME <i>Fisher Wright</i>	
13b. MOTHER'S MAIDEN NAME <i>Esther Stockton</i>		14. NAME OF HUSBAND OR WIFE <i>Mary Wright</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>487-05-1113</i>	
17. INFORMANT <i>Mary Wright</i>		Address <i>5209 Pryor Ave.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Stomach</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN ONSET AND DEATH <i>6 MO</i>
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 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.) <i>Jan 58</i>	20f. CITY, TOWN, OR LOCATION <i>St. Joseph Mo</i>	COUNTY _____	STATE _____
21. I attended the deceased from <i>Jan 58</i> to <i>8-1-59</i> and last saw her/him alive on <i>8-1-59</i> Death occurred at <i>3:30 p</i> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (In green or title) <i>Clemens C. Woodell Mo</i>		22b. ADDRESS <i>St. Joseph Mo</i>	22c. DATE SIGNED <i>8-3-59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Aug. 4, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>
24. FUNERAL DIRECTOR <i>Clark Funeral Home</i>		25. DATE RECD. BY LOCAL REG. <i>Aug 3, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Clark Woodell</i>

DOCUMENT

C.L. DuMont Medical Certification

BY AFFIDAVIT OF

NOV 20 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Alvin E. Bagan

Licensed Embalmer No. 4790

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.