

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 17 1960

-60-030930

STATE FILE NUMBER

Registration District No. 146 Primary Registration District No. 3026 Registrar's No. 376

1. PLACE OF DEATH a. COUNTY Jackson				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		Length of stay in 1b 3 weeks		c. CITY OR TOWN Independence		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Independence Sanit.Hosp.			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 323 E. Lexington		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louie Middle Asburn Last Wright				4. DATE OF DEATH Month Aug. Day 5 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 5-20-1908	9. AGE (last birthday) 52	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) Truck Driver			10b. KIND OF BUSINESS OR INDUSTRY Toede Transfer Co.		11. BIRTHPLACE (City and state or country) Keytsville, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Preston Wright			13b. MOTHER'S MAIDEN NAME Elizabeth Howard			14. NAME OF HUSBAND OR WIFE Ruth Wright		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 493-12-6717		17. INFORMANT Address Mrs. Ruth Wright Independence, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5mo</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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		
19. WAS AUTOPSY PERFORMED? YES <input 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.)				
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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from <u>5-27-60</u> to <u>6 Aug 60</u> and last saw ^{her} him alive on <u>6 Aug 60</u> Death occurred at <u>6:45 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>J. H. Anderson</u> (Degree or title)				22b. ADDRESS <u>Independence</u>		22c. DATE SIGNED <u>8-6-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 8, 1960	23c. NAME OF CEMETERY OR CREMATORY Keytsville, Mo. Cemetery		23d. LOCATION (City, town, or county) (State) Keytsville, Missouri			
24. FUNERAL DIRECTOR ADDRESS Geo. C. Carson & Sons Independence, Mo.				25. DATE RECD. BY LOCAL REG. 8-8-60		26. REGISTRAR'S SIGNATURE <u>J. H. Anderson</u>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 20 1961

AUG 18 1960

VS FEB 24 1961

VS AUG 17 1960

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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Indy, 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.