

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037311

FILED VS NOV 7 1960

STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 570 Registrar's No. 323

DED

1. PLACE OF DEATH a. COUNTY Adair				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Adair				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkville		Length of stay in 1b		c. CITY OR TOWN Kirkville		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION R.F.D.#2			Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) R.F.D.#2		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSCOE Middle F. Last WRIGHT				4. DATE OF DEATH Month Oct. Day 27 Year 1960				
15. 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 12-13-1888	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) La Plata, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME James R. Wright			13b. MOTHER'S MAIDEN NAME Icaphane Bragg			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----			16. SOCIAL SECURITY NO. 492-44-1292		17. INFORMANT Address Wm. Wright, Kirkville, Mo			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency							15 Min.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Chronic Coronary Artery Disease							6 yrs.	
DUE TO (c) Arteriosclerosis							unknown	
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 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.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE
21. I attended the deceased from 8/1/53 to 10/22/60 and last saw him alive on 10/22/60 Death occurred at 5:30 pm on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <i>[Signature]</i>				22b. ADDRESS Kirkville, Mo.			22c. DATE SIGNED 10-29-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-29-1960	23c. NAME OF CEMETERY OR CREMATORY Refuge Cemetery		23d. LOCATION (City, town, or county) (State) Kirkville, Mo.			
24. FUNERAL DIRECTOR ADDRESS Davis & Davis, Kirkville, Mo.				25. DATE RECD. BY LOCAL REG. 11-4-1960		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ED BESTMANN, D.O.

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 Robert B. Davis

Licensed Embalmer No. 4219

P. O. Address Kirksville, M

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