

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-022117

STATE FILE NUMBER

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 663

FILED JUN 18 1962

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

15117

25117

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION
Dr. D. Craig M. P.

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in lb <u>45 Yrs</u>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Joseph's Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1212 South 6th</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREDERICK R. WRIGHT</u>			4. DATE OF DEATH Month Day Year <u>June 6, 1962</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1890</u>
9. AGE (last birthday) <u>71</u>		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) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armour & Co.</u>	11. BIRTHPLACE (City and state or country) <u>Platte Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>James W. Wright</u>	
13b. MOTHER'S MAIDEN NAME <u>Sarah Ellen McMullen</u>		14. NAME OF HUSBAND OR WIFE <u>Edith</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>[REDACTED]</u>	17. INFORMANT <u>Mrs Carrie DeVore</u> Address <u>St. Joseph, Mo.</u>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Decompensation</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertensive Heart Disease</u> 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 <u>Unknown</u> <u>Unknown</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 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>10/8/52</u> to <u>6/6/62</u> and last saw ^{him} her alive on <u>6/6/62</u> Death occurred at <u>6:15 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Arthur W. Helms MD</u>		22b. ADDRESS <u>Social Welfare Board 10th & Olive, St. Joseph, Mo.</u>	22c. DATE SIGNED <u>6/7/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>June 9, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Blakely Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Buchanan Co. Mo.</u>
24. FUNERAL DIRECTOR <u>H.O. Sidempfel & Son R.R. 7.</u>	ADDRESS <u>St Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 8, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Goodell</u>

USE BLACK INK OR TYPEWRITER RIBBON

Welfare

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 Robert H. Gaylor

Licensed Embalmer No. 3308

P. O. Address St. Joseph, 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.