N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

UNFADING INK—THIS IS A PERMANENT RECORD

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Pettis — Heaton

Township ________ or Village ________ or City Sedalia (No. 500 W 6th St.; 4 Ward)

Registration District No. 668 File No. 40274

Primary Registration District No. 3132 Registered No. 295

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Samuel Wright

PERSONAL AND STATISTICAL PARTICULARS	
SEX	Male
COLOR OR RACE	white
SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)	married
DATE OF BIRTH (Month) (Day) (Year)	Aug 1, 1830
AGE	83 yrs. 4 mos. 13 ds.
If LESS than 1 day, ___ hrs. or ___ min.?	
OCCUPATION (a) Trade, profession, or particular kind of work	Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)	Retail
BIRTHPLACE (City or town, State or foreign country)	Penn.
PARENTS — NAME OF FATHER	Samuel Wright
BIRTHPLACE OF FATHER (City or town, State or foreign country)	Penn
MAIDEN NAME OF MOTHER	Anna Moore
BIRTHPLACE OF MOTHER (City or town, State or foreign country)	Penn. U. S. A.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W H Wright — son

(ADDRESS) St Louis Mo

Filed Dec 13, 1913 F. B. Long By M. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Dec 11, 1913 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Aug, 1912, to Dec 11, 1913, that I last saw him alive on Dec 11, 1913, and that death occurred, on the date stated above, at 11:45 p.m.

The CAUSE OF DEATH* was as follows:

General Debility of Senility

Aug (Duration) 1 yrs. 4 mos. ___ ds.

Contributory (SECONDARY) ________ (Duration) ___ yrs. ___ mos. ___ ds.

(Signed) A H Heaton, M. D.

Dec 13, 1914 (Address) 115 E 4th

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? ________

Former or usual residence ________

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Crown Hill Cemetery	Dec 14, 1913
UNDERTAKER	ADDRESS
McLaughlin Bros	Sedalia Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____, _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

_____ (Month) _____ (Day) 1_____ (Year)

AGE

_____ yrs. _____ mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

_____, 191____
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from _____, 191____, to _____, 191____, that I last saw h_____ alive on _____, 191____, and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

_____

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191____
UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.