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.

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

1 PLACE OF DEATH

County: Jasper

Township or Village or City: Webb City (NO. 416 N. Hall St.; Ward)

Registration District No.: 417 / 304

Primary Registration District No.:

File No.: 37204 / 36

Registered No.:

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

2 FULL NAME: Mary E. Wright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Sept. (Month) 23 (Day) 1863 (Year)

7 AGE: 57 yrs. 2 mos. 19 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Illinois

PARENTS

10 NAME OF FATHER: Dexter Hand

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Ind.

12 MAIDEN NAME OF MOTHER: Adelia Smith

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. M. Wright
(Address): Webb City

15 Filed: 12/14, 1920. C. C. McCaulie, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec. (Month) 12 (Day), 1920 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Apr 1919, 1919, to Dec 12, 1920, that I last saw her alive on Dec 12, 1920, and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

87.1 Acute apoplexy

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

CONTRIBUTORY (Secondary)

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

(Signed): James J. O'Brien M. D.

Dec 13, 1920 (Address): Webb City Mo

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

18 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

19 PLACE OF BURIAL OR REMOVAL: Mt Hope Cem. DATE OF BURIAL: Dec 16, 1920

20 UNDERTAKER: Steele Und. Co. ADDRESS: Webb City Mo.

LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ....., ... St.; ..... Ward)

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

2 FULL NAME .....

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.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ....., 1..... (Year)

FEB 20 1953

7 AGE ..... yrs. ..... mos. ..... ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ....., 191..... (Year)

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS