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

PLACE OF DEATH

County: Lee Kalb

Township: ~~Polk~~

or Village: Union Star

or City: _____ (NO. _____, _____ St.: _____ Ward)

Registration District No. ~~4161~~ 262

Primary Registration District No. ~~262~~ 4161

File No. 31923

Registered No. _____

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

FULL NAME William C Wright

PERSONAL AND STATISTICAL PARTICULARS

SEX: male

COLOR OR RACE: white

SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): under

DATE OF BIRTH: 1834 (Month) April (Day) 6 (Year)

AGE: 85 yrs. 7 mos. ___ ds.

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

OCCUPATION—
(a) Trade, profession, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): _____

BIRTHPLACE (City or town, State or foreign country): Ross County ohio

PARENTS

NAME OF FATHER: Cristifer C Wright

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

MAIDEN NAME OF MOTHER: Mary Fitzwilians

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

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rena Veale

(ADDRESS) Hugh Stanton

Filed Dec 7, 1921. E M Reynolds REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: December (Month) 6th (Day), 1921 (Year)

I HEREBY CERTIFY, that I attended deceased from ~~November 29~~ 1921, to December 6, 1921, that I last saw him alive on December 5, 1921, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Cerebra Spinal Sclerosis

87B

(Duration) One yrs. ___ mos. ___ ds.

Contributory (SECONDARY) _____

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

(Signed) A D Varner M. D.

Dec 7th 1921 (Address) Union Star Mo

*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: Union Star Mo

DATE OF BURIAL: Dec 6 1921

UNDERTAKER: W L Cole

ADDRESS: King City Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state [illegible]

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

PLACE OF DEATH

County _____

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

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) _____ (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 _____ (Month) _____ (Day), 191__ (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