

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

Do not use this space.

AUG 17 1927

(2)

**1. PLACE OF DEATH**

County Laclede Registration District No. 451  
Township Eldredges Primary Registration District No. 5616  
City (No. .... St. .... Ward)

File No. 221816  
Registered No. ....  
St. .... Ward)

**2. FULL NAME**

Martin H. Wright

(a) Residence. No. .... St. .... Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX M 4. COLOR OR RACE C 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Decoste

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept. 29 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
59 9 13

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work Messenger  
(b) General nature of industry, business, or establishment in which employed (or employer) St. Capital Springfield, Ill  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Springfield Ill

10. NAME OF FATHER Richard Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) N. Carolina

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT (Address) Millard Wright 116 N. B. St. Springfield Ill

15. FILED July 19 27 Emma B. Byrd REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 12 1927

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19....., and that I last saw h..... alive on ..... 19....., and that death occurred, on the date stated above, at 9:15 m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Apple core  
sudden  
CONTRIBUTORY (SECONDARY) none  
(duration) yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

Did an OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) [Signature], M. D.  
, 19 (Address) Decaturville Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Springfield Ill DATE OF BURIAL July 16 1927

20. UNDERTAKER Palmer ADDRESS Lebanore

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.

