

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

Do not use this space.

32434

1. PLACE OF DEATH
 County Schuyler Registration District No. 803 File No. 54
 Township _____ Primary Registration District No. _____ Registered No. _____
 City Elenwood (No. U.S. 1-1) St. _____ Ward _____

2. FULL NAME Daniel J. 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. mes. ds. How long in U.S., if of foreign birth? yrs. mes. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7 - 1859

7. AGE YEARS MONTHS DAYS 68 10 5 If LESS than 1 day, _____ hrs. or _____ min.

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

9. BIRTHPLACE (CITY OR TOWN) Schuyler Co Mo (STATE OR COUNTRY)

10. NAME OF FATHER Washington Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Lucinda Brown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known (STATE OR COUNTRY)

14. INFORMANT E. E. Wright (Address) Green City Mo

15. FILED 9/18 1928 Geo. Raubo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 19 28

17. I HEREBY CERTIFY That I attended deceased from Sept 4 1928 to Sept 12 1928 that I last saw him alive on Sept 10 1928, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATHS WAS AS FOLLOWS:
Heart Lesion & Bright's disease
950
1378 (duration) cardi yrs. mes. ds.
 CONTRIBUTORY 107A
Pneumonia (duration) _____ yrs. mes. ds.

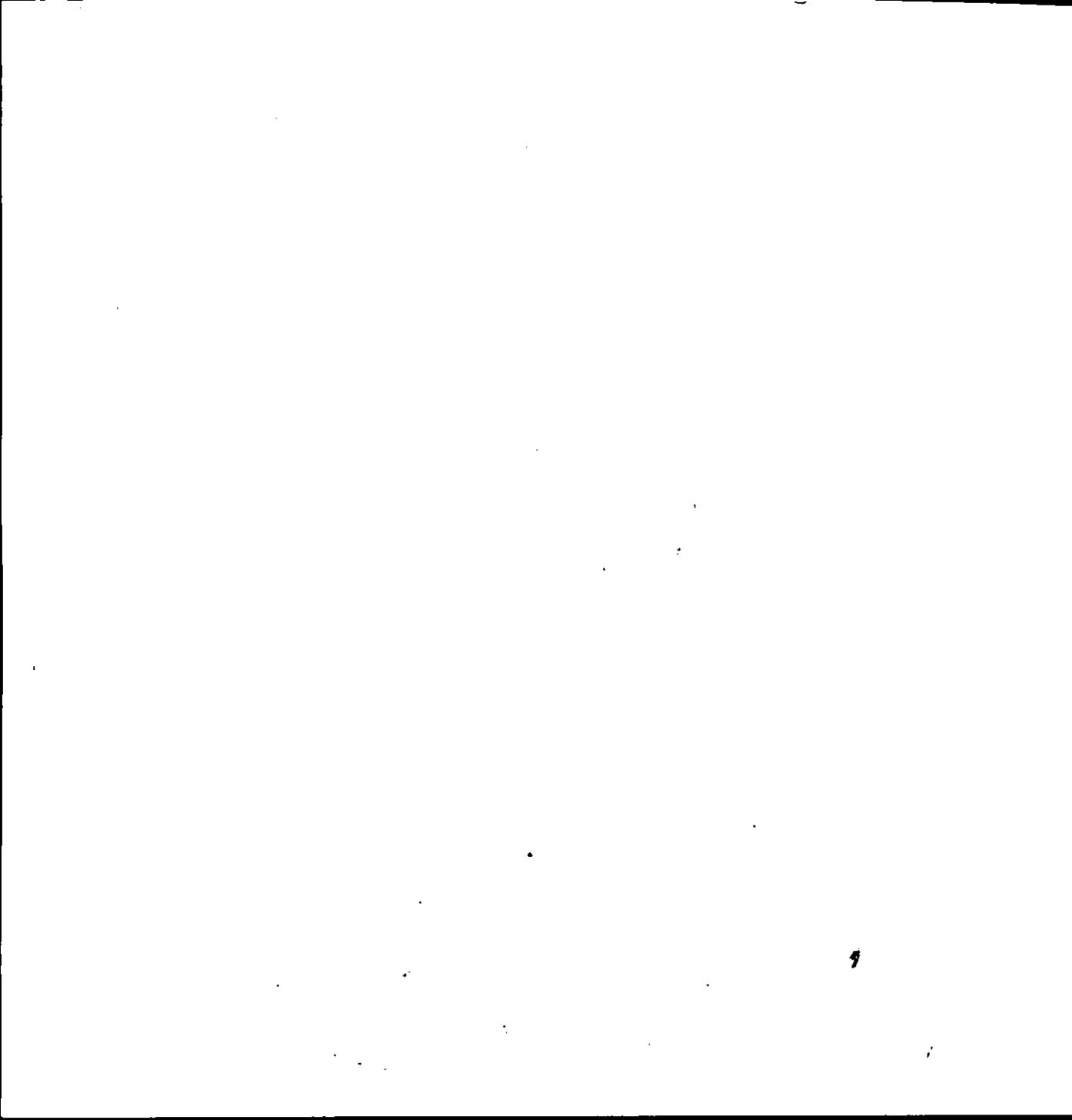
18. WHERE WAS DISEASE CONTRACTED Schuyler Co Mo
 IF NOT AT PLACE OF DEATH? _____
 DID AN OPERATION PRECEDE DEATH? No DATE OF _____
 WAS THERE AN AUTOPSY? No
 WHAT TEST CONFIRMED DIAGNOSIS Ken. Dysentery
 (Signed) Zafayette H. C., M. D.
 (Address) Queen City Mo.

*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 Grintown Cemetery DATE OF BURIAL Sept 14 1928

20. UNDERTAKER John A. Roberts ADDRESS Lancaster Missouri

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**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Shuyler Registration District No. 803 File No. 54
 Township..... Primary Registration District No. 44.82 Registered No.....
 City Georgetown (No.....) St. Ward)

2. FULL NAME Daniel J. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 7 - 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 10 5

8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address).....

15. FILED 19 Geo. Raubo REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 12 19 28

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Heart Lesion of Brights Disease
Bunghial (duration)..... yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) pneumonia (duration)..... yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH.....
 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....
 WAS THERE AN AUTOPSY?.....
 WHAT TEST CONFIRMED DIAGNOSIS?.....
 (Signed)....., M. D.
 , 19 (Address)

*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 DATE OF BURIAL
 19

20. UNDERTAKER ADDRESS

SUPPLEMENTARY

DO NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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