JUN 25 1929

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

Do not use this space.

17609

1. PLACE OF DEATH
County Clay. Registration District No. 198 File No.
Township Fishing River Primary Registration District No. 3011 Registered No. 68
City Ex Spgs (No. St. Ward)

2. FULL NAME Robert W Wright
(a) Residence. No. Royal Hotel St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 23 - 1858

7. AGE: Years 71 Months 3 Days 1 If LESS than 1 day, hrs. or min.

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

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kokomo. Ind

PARENTS
10. NAME OF FATHER: Un Known
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Un Known
12. MAIDEN NAME OF MOTHER: Un Known
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Un Known

14. INFORMANT: Frank Benson
(Address) Excelsior Spgs MO

15. FILED 6/24 1929 Yd. Craven REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 1929

17. I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 24, 1929, that I last saw him alive on May 24, 1929, and that death occurred, on the date stated above, at 1130 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Preparation of Stomache
1175
129 (duration) yrs. mos. 9 ds.
CONTRIBUTORY (SECONDARY) Peritonitis
(duration) yrs. mos. 5 ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH refused
DID AN OPERATION PRECEDE DEATH? No DATE OF
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Unusual Symptoms of abort
(Signed) E Lawrence, M. D.
, 19 (Address) Excelsior Spgs 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: Crown Hill Cemetery
DATE OF BURIAL: May 26 1929
20. UNDERTAKER: John C Prather
ADDRESS: Ex Spgs

CAUSE OF ... supplied. AGE should be stated ... PHYSICIANS should state ... properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County: Clay — Registration District No.: 198 — File No.:
Township: Excelsior Spgs — Primary Registration District No.: 3011 — Registered No.: 68
City: Excelsior Spgs (No. , St. Ward)

2. FULL NAME: Robert W. Wright

(a) Residence. No. St., Ward. (If nonresident, give city or town and State)
(Usual place of abode)
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): Wid

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

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

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(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)

PARENTS
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 5/24 1929 — G. D. Craven — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 1929

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Perforation of Stomach due to Ulceration
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (SECONDARY) Peritonitis
(duration) yrs. mos. 8 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

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in such a way that it may be properly classified. Exact statement of OCCUPATION is very important.

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

S-[illegible]