

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

Do not use this space.

5333

**1. PLACE OF DEATH**

County Jasper  
Township \_\_\_\_\_  
City Alba, Missouri (No. \_\_\_\_\_)

Registration District No. 405  
Primary Registration District No. #239

File No. \_\_\_\_\_  
Registered No. 1  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Priscilla Ann 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 20, 1844

7. AGE YEARS MONTHS DAYS if LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
85 11 20

**8. OCCUPATION OF DECEASED**

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

9. BIRTHPLACE (CITY OR TOWN) Brown County  
(STATE OR COUNTRY) Illinois

10. NAME OF FATHER John Dale

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

12. MAIDEN NAME OF MOTHER Priscilla P. Hill

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

14. INFORMANT Mrs. Dora Elliott  
(Address) 1805 Virginia - Joplin, Mo.

15. FILED 2-12-1930 Effie Green  
REGISTRAR

**3 MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 12 1930

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Jan 29, 1930, that I last saw her alive on Jan 29, 1930, and that death occurred, on the date stated above, at 7 2 M

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

Chronic Bright's disease.

10 1/2 (duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (SECONDARY) Broken hip.  
(duration) yrs. mos. 28 ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

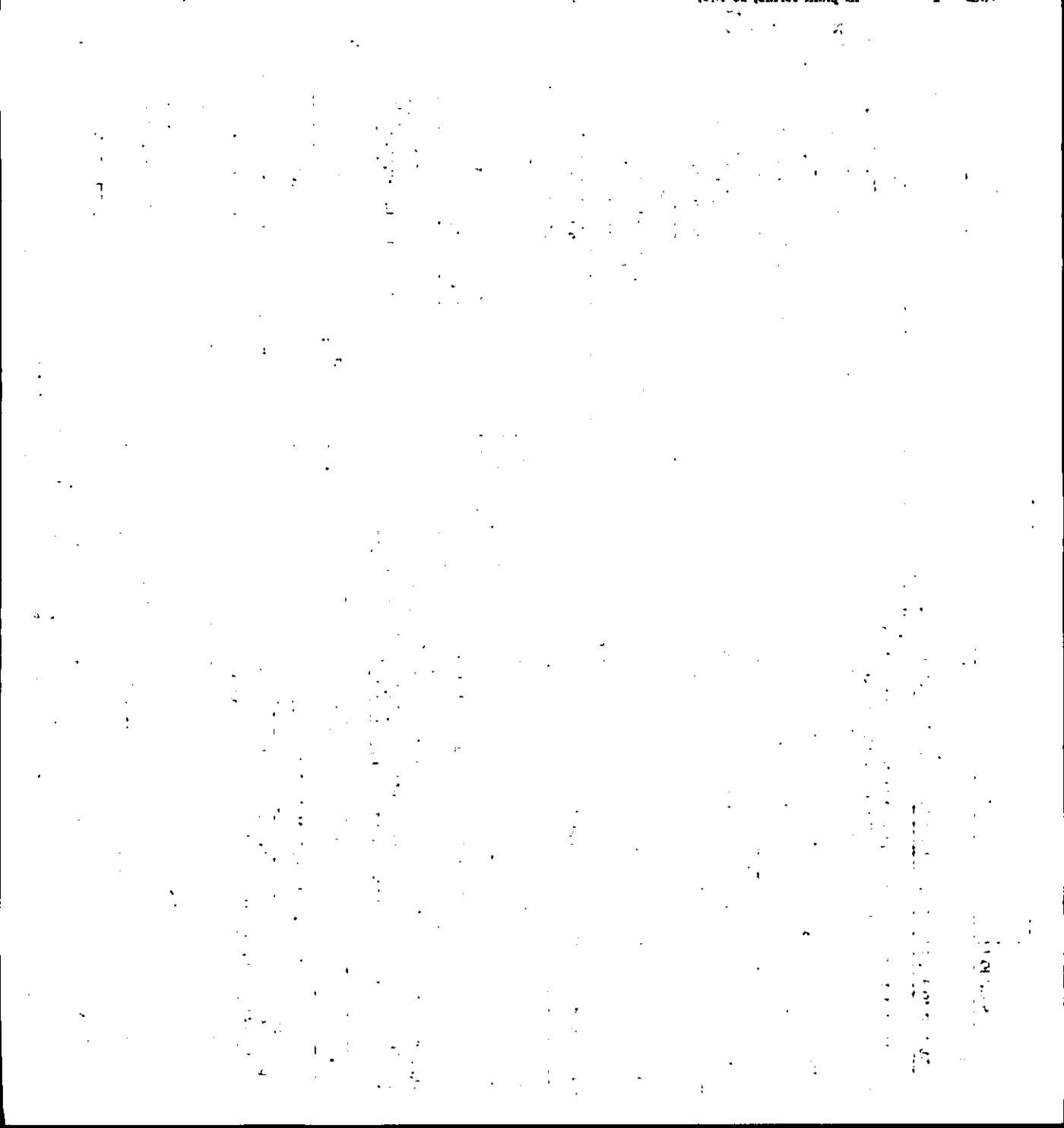
20. WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS  
(Signed) D. A. Kearley, M. D.  
2-12-1930 (Address) Alba, 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 Lawer Cemetery DATE OF BURIAL Feb. 13 1930

20. UNDERTAKER Kneel Mortuary ADDRESS Portage, Mo.



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CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH.**

County Gasconade  
Township Albion  
City Albion (No. .... St. .... Ward)

Registration District No. 405-  
Primary Registration District No. 4239

File No. ....  
Registered No. 1

**2. FULL NAME** Orville Ann 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**

**MEDICAL CERTIFICATE OF DEATH**

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 12 19 30

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

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

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

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

CONTRIBUTORY (SECONDARY) Broken hip (duration) yrs. mos. ds.

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

accident - fell when she tried to get up out of her chair. (duration) yrs. mos. ds.

10. NAME OF FATHER

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

12. MAIDEN NAME OF MOTHER

WAS THERE AN AUTOPSY?.....

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

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) 185 M. D.

, 19 (Address) 6

\*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.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 4-10-30 Effie Green REGISTRAR

20. UNDERTAKER ADDRESS

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

CAUSE OF DEATH exact statement of OCCUPATION is very important. that it may be properly classified.

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