ON 25

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

Do not use this space.

15741

1. PLACE OF DEATH
County: DeKalb
Township: Camden
City: Maysville (No. ..... St. ..... Ward)

Registration District No. 259
Primary Registration District No. 4158

File No. .....
Registered No. .....

2. FULL NAME: Dolletta Lorene 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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word):

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Jan 1, 1924

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
6	4	5	

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): DeKalb Co. Mo

PARENTS

10. NAME OF FATHER: Chas. Wright
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Ray Co Mo
12. MAIDEN NAME OF MOTHER: Mary E. Yallaly
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): DeKalb Co Mo

14. INFORMANT (Address): Charles Wright

15. FILED May 5, 1930 J. L. Phelps REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 5th 1930

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1930, at ten o'clock May 5 1930, to ..... that I last saw her alive on May 5, 1930, and that death occurred, on the date stated above, at 11 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
7 Measles with Bronchial Pneumonia
NTB
107A (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Spinal Bifidia
..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. L. Phelps, M. D.
, 19 (Address) Maysville 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: New Hope
DATE OF BURIAL: 5/6 1930

20. UNDERTAKER: J. L. Davis
ADDRESS: Maysville Mo

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.