

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

Do not use this space.

5880

1. PLACE OF DEATH

County Jackson Registration District No. 8
 Township Frank Primary Registration District No. 170
 City St. Joseph, Mo. (No. 28) St. Joseph Hospital St. 974 Ward 4

2. FULL NAME

Dr. Cleo Estell Wright
 (a) Residence. No. 2830 Harrison St. St. 4 Ward. 4
 (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 Wh. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 19 - 1903

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
27 4 8

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dentist
 (b) General nature of industry, business, or establishment in which employed (or employer) Own practice
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) 1

PARENTS

10. NAME OF FATHER E. R. Wright

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

12. MAIDEN NAME OF MOTHER Minnie E. Yemmi

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

14. INFORMANT E. R. Wright (Address) 2830 Harrison

15. FILED 2/27, 1931 M. M. Crowe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 27 1931

17. I HEREBY CERTIFY, That I attended deceased from 2-23, 1931, to 2-27, 1931 that I last saw him alive on 2-26, 1931, and that death occurred, on the date stated above, at 7:05 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Pneumonia

7 3/4 (duration) yrs. mos. ds. 5

CONTRIBUTORY (SECONDARY) Pulmonary Tuberculosis (duration) yrs. mos. ds. unknown - probably several years

18. WHERE WAS DISEASE CONTRACTED residence IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no SURVIVAL FINDINGS + TEST CONFIRMED DIAGNOSIS no

(Signed) Paul J. ... M.D. (Address) 814 Prof Bldg

*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 Savannah, Mo DATE OF BURIAL March 1 1931

20. UNDERTAKER Mrs. E. L. Forster ADDRESS K. C. 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.

804 Professional
Vic - 9224

- 1:30 pm.