

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

Do not use this space.

22135

1. PLACE OF DEATH

67 County Texas
Township Charleston
City Charleston (No. _____)

Registration District No. 566
Primary Registration District No. 3036

File No. _____
Registered No. 52
St. _____ Ward) _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward. _____
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 22 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>M</u>	4. COLOR OR RACE <u>Wh</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>S</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____				
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>12/16/1929</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>1</u>	<u>5</u>	<u>22</u>	

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) Charleston
(STATE OR COUNTRY) Mo

10. NAME OF FATHER H.O. Wright

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

12. MAIDEN NAME OF MOTHER Mildred

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Cape Girardeau
(STATE OR COUNTRY) mo. 1

14. INFORMANT James Joe
(Address) Charleston Mo.

15. FILED June 8 1931 J.S. Vann
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 6/7 7:00 PM 1931

17. I HEREBY CERTIFY, That I attended deceased from 6/5, 1931, to 6/7, 1931, that I last saw h. ER alive on 6/7, 1931, and that death occurred, on the date stated above, at 7:00 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Enterocolitis
11913
1097 (duration) _____ yrs. _____ mos. 7 ds.

CONTRIBUTORY Bronchial pneumonia
(SECONDARY) (duration) _____ yrs. _____ mos. 1 ds.

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

DID AN OPERATION PRECEDE DEATH no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) E. Chas. Pluring M.D.
, 19 _____ (Address) Charleston 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 St. Cypriety Sexton
DATE OF BURIAL 6/8 1931

20. UNDERTAKER Lace and Co
ADDRESS Charleston Mo.

N. B.—Every item of info. CAUSE OF DEATH in plain-text should be properly classified. EXACTLY.

