

Dr Raines

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

Do not use this space.

34999

1. PLACE OF DEATH

County Macon  
Township Middlefork  
City Glen

Registration District No. 135-  
Primary Registration District No. 5719

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

2. FULL NAME Glen Wright

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(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 Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
60 - - -

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Farmer

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

13. NAME D.A.

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.A.

15. MAIDEN NAME D.A.

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) D.A.

17. INFORMANT (ADDRESS) Mrs Sallie Wright  
Macon, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Milledy Lane DATE 11-21-1931

19. UNDERTAKER (ADDRESS) Stephens & Gooding  
Macon, Mo.

20. FILED \_\_\_\_\_, 19\_\_\_\_ Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 31, 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 1, 1931, to Oct 3, 1931.

I last saw him alive on Oct 20, 1931. Death is said to have occurred on the date stated above, at 7:00 p.m.

The principal cause of death and related causes of importance were as follows:

Chronic nephritis  
131  
132B

Other contributory causes of importance:

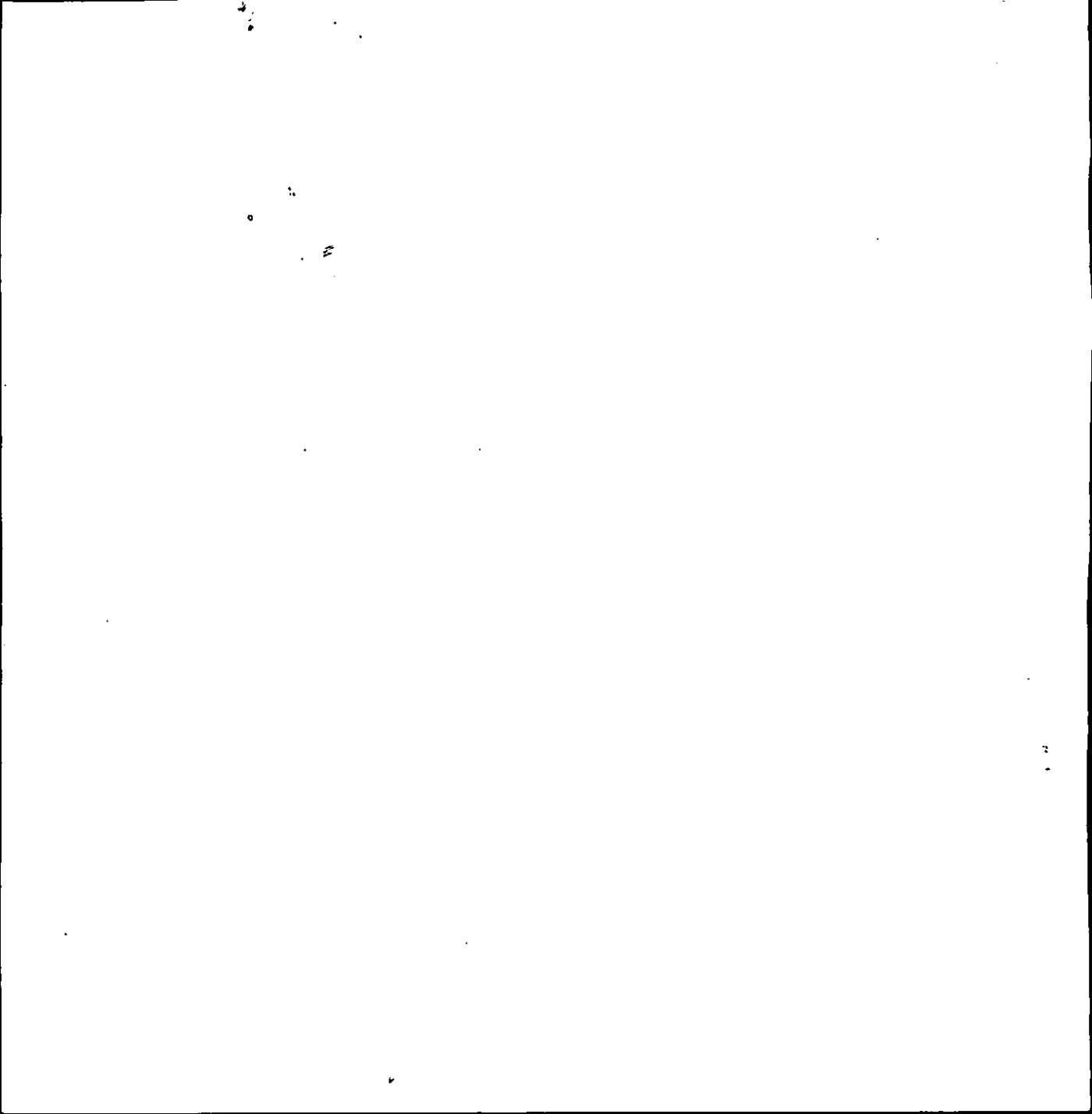
Name of operating physician \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.  
Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) A. M. Raines, M. D.  
(Address) Macon Mo



**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 Macon  
Township Middlefork  
City (No. \_\_\_\_\_) \_\_\_\_\_

Registration District No. 535-  
Primary Registration District No. 5719

File No. 1  
Registered No. 46  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Glen 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 M 4. COLOR OR RACE Col 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1871

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	<u>60</u>	<u>-</u>	<u>-</u>	

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

13. NAME Don

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) Mrs Sallie Wright  
macon mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Miller cem. DATE 11-2-31 1931

19. UNDERTAKER (ADDRESS) Stephens & Goodding  
macon mo

20. FILED Dec. 10, 1931 J. J. King Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 31 1931

22. I HEREBY CERTIFY, That I attended deceased from Oct 1 - 1931 to Oct 31 1931

I last saw him alive on Oct 30 1931. Death is said to have occurred on the date stated above, at 7:00 p m.

The principal cause of death and related causes of importance were as follows:

Septic poisoning Date of onset \_\_\_\_\_  
Chronic nephritis

Other contributory causes of importance: \_\_\_\_\_

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19 \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_

(Signed) A. M. Raines, M. D.  
(Address) macon mo

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

SUPPLEMENTARY

S-34999