

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

26193
Do not use this space.

REC'D AUG 10 1939

1. PLACE OF DEATH

(a) County Mason Registration District No. 535
 (b) Township Nappau Primary Registration District No. 5720
 (c) City Callao (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

1623 William Allen Wright
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 29, 1939

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

22. I HEREBY CERTIFY, That I attended deceased from June 29, 1939, to June 29, 1939

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 16 - 1896

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 1:30 p.m.

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
53 5 13

The principal cause of death and related causes of importance were as follows:
Acute myocardial infarction
Also of minor importance

OCCUPATION 8. Trade, profession, or particular kind of work done, as a sawyer, bookkeeper, etc. Miner W. P. A.
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

Date of onset June 25
 Other contributory causes of importance: None

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mason Co Mo

FATHER 13. NAME William C. Wright
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mason Co Mo

MOTHER 15. MAIDEN NAME Sarah Perkins
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mason Co Mo

17. INFORMANT (ADDRESS) Mrs Wm Wright
Callao Mo

18. BURIAL, CREMATION, OR REMOVAL
 X PLACE DATE _____ 19____

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Henry Edwards
Thomas E. Blevins

20. FILED Aug 4, 1939 Gela King
 Local Registrar.

Name of operation None Date of _____
 What test confirmed diagnosis Heart Was there an autopsy? Yes

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? at residence
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
 Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Edward R. ... M. D.

(Address) New Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Every year of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

61

RECEIVED

District Health Officer No. 10

District File Number 8-39-1397

Date Filed AUG 7 1939

*Mrs. Della Williams
Ex-130-*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.