

NOV 22 1939

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

36309  
Do not use this space.

1. PLACE OF DEATH

(a) County JACKSON Registration District No. 400  
 (b) Township PRAIRIE Primary Registration District No. 55527B Registered No. 197  
 (c) City \_\_\_\_\_ (d) Street No. Jackson County Emergency Hospital St. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred 8 yrs. mos. ds. (f) How long in U. S. If of foreign birth? yrs. mos. da.

2. PRINT FULL NAME MRS. INA WRIGHT

(a) Residence, No. NEES SUMMIT 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

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 17 1866

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hra. or .....min.  
73 1 21

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None  
 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 \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Bolivar, Mo.

FATHER 13. NAME Harvey Mitchell

14. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Tenn.

MOTHER 15. MAIDEN NAME Emily Hendricks

16. BIRTHPLACE (CITY OR TOWN, STATE OR COUNTRY) Virginia

17. INFORMANT (ADDRESS) JACKSON CO. HOSPITAL

18. BURIAL, CREMATION, OR REMOVAL Catholic Cemetery DATE Oct-10-1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Fields James  
1000 Lees Summit Mo

20. FILED 10/9/1939 Sara G Barnes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 8 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1939, to Oct. 8, 1939  
 I last saw her alive on Oct. 8, 1939. Death is said to have occurred on the date stated above, at 3-15 p.m.  
 The principal cause of death and related causes of importance were as follows:

Permeous anemia  
malnutrition  
rupture of st. stomach

Name of operation none Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? suicide 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? yes

If so, specify Permeous anemia  
 (Signed) Lee G. Cook, M. D.  
Jackson Co. Emrgy Hosp.  
Pitts Bluff, Mo

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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**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..... *P. C. Fields*.....

Licensed Embalmer No. *2957*.....

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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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36309  
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1. PLACE OF DEATH

(a) County Jackson Registration District No. 400  
(b) Township Prarie Primary Registration District No. 5533 Registered No. ....  
(c) City ..... (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 Mrs Ina 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

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wed

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
73 1 21

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

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 8, 1939

22. I HEREBY CERTIFY, That I attended deceased from

to

I last saw h. alive on

to

Death is said

to have occurred on the date stated above, at

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

Refrigerious Anemia  
Dr. moved leaving  
no address - No Mrs. D.

Other contributory causes of importance:  
malnutrition  
Fracture of rt. Humerus

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

23. If death was due to external cause (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) Lee E. Rankin, M. D.  
(Address) Jackson, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY 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.

SUPPLEMENTARY

