

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

36312  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Jackson Registration District No. 400  
 (b) Township Oraine Primary Registration District No. 555319 Registered No. 201  
 (c) City \_\_\_\_\_ (d) Street No. Jackson County Home further east + unknown  
 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 Bert Wright  
 (a) Residence, No. J. C. Home 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 Male 4. COLOR OR RACE White 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) Nov-20-1870

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>68</u>	<u>10</u>	<u>23</u>	

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

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) Kentucky

FATHER

13. NAME Unknown

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

MOTHER

15. MAIDEN NAME Unknown

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

17. INFORMANT Ernest Jackson  
 (ADDRESS) J. C. Home

18. BURIAL, CREMATION, OR REMOVAL Wellsville Mo. DATE Oct 16 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Rubens Wellsville Mo.

20. FILED 10-15-39 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 13 1939

22. I HEREBY CERTIFY, That I attended deceased from 9-1-39 to 10-1-39  
 I last saw him alive on 10/12/39 Death is said to have occurred on the date stated above, at 11:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Mitral regurgitation Date of onset \_\_\_\_\_

Other contributory causes of importance: HTN

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis: clinical Was there an autopsy? no

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? no  
 If so, specify \_\_\_\_\_ (Signed) J. W. Geave, M. D.  
Independence (Address) \_\_\_\_\_

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.....

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.**