

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

40544  
Do not use this space.

1. PLACE OF DEATH *Pike* Registration District No. *686*  
 (a) County *Spencer* Primary Registration District No. *6913* Registered No. *6*  
 (b) Township \_\_\_\_\_  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St.  
 (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 *MARGARET CATHERINE 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 *Female* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Widowed*  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John W Wright*  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Jan 28 1858*  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
*81 8 1*  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Housewife*  
 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) *New Harmony Ind*  
 FATHER 13. NAME *Wm N Braustetter* 9  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *West Virup*  
 MOTHER 15. MAIDEN NAME *Mary M. Goodman*  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Virginia*  
 17. INFORMANT (ADDRESS) *Mrs. Cole Heim*  
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Kelby Pike Co* DATE *Oct 29 39*  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *W. S. Waters, Vandalia*  
 20. FILED *Nov 27, 1939* *Gene E. Hendry* Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Oct 27 1939*  
 22. I HEREBY CERTIFY, That I attended deceased from *Oct 16 1939* to *Oct 27 1939*  
 I last saw him alive on *Oct 26 1939*. Death is said to have occurred on the date stated above, at *530 P.M.*  
 The principal cause of death and related causes of importance were as follows:  
*Branchio Bronchitis*  
*Chronic Valvular Heart Disease*  
 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) *H. H. Blair* M. D.  
 (Address) *Vandalia*

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.

RECEIVED

District Health Officer No. 10

District File Number 12-39-2058

Date Filed DEC 5 1939

**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 Wm. B. Waters

Licensed Embalmer No. 3325

P. O. Address Vandalia Mo

**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.