

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

43514
Do not use this space.

1. PLACE OF DEATH

(a) County Howard Registration District No. 878
 (b) Township _____ Primary Registration District No. 4222 Registered No. _____
 (c) City Fayette (d) Street No. See Hospital Fayette Missouri 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

(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 Male 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (use the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7/5th 1875

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day,hrs. ormin.
<u>64</u>		<u>5</u>	<u>12</u>	

OCCUPATION 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) Missouri.

FATHER 13. NAME Adam Wright.
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri.

MOTHER 15. MAIDEN NAME Mary Samuel,
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri,

17. INFORMANT (ADDRESS) Lucy Wright.
Fayette, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE City Cemetery DATE 12/20th 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Guy T. Halley.
Fayette, mo.

20. FILED Jan. 5 1940 V. C. Bonham
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-17th 1939 1939

22. I HEREBY CERTIFY, That I attended deceased from 12-6, 1939, to 12-17, 1939. I last saw him alive on 12-17, 1939. Death is said to have occurred on the date stated above, at 3:10 P.M.
 The principal cause of death and related causes of importance were as follows:
mesenteric Thrombosis
myocardial Failure
 Date of onset 12-15-39

Other contributory causes of importance:
Post-operative inanition
Hypertensive Cardio-vascular Syndrome

Name of operation Arterioscleroly (left) Date of 12-6-39
 What test confirmed diagnosis? _____ 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? _____ (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) Shed W. Lundgren M. D.
See Hospital, Fayette Mo (Address)

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.

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1/11/40

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.