

**FEB 17 1940**  
Registration District No. 102

Primary Registration District No. 4062

Registrar's No. 33

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Huyvasse  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
X  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution X (Specify whether  
In this community 14 Months  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Callaway  
(c) City or town Huyvasse  
(If outside city or town limits, write "RURAL")  
(d) Street No. X (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 8<sup>th</sup>  
year 1940 hour 8 minute 0 P. M.

21. I hereby certify that I attended the deceased from  
January 1, 1940 to January 8, 1940  
that I last saw him alive on January 8, 1940  
and that death occurred on the date and hour stated above.  
Immediate cause of death Stenosis Duration \_\_\_\_\_

3. (a) PRINT FULL NAME Thomas Theodore Wright  
3. (b) If veteran, name war X 3. (c) Social Security No. X

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife X 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased Dec. 30 1881  
(Month) (Day) (Year)

8. AGE: Years 59 Months 0 Days 8 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Montgomery Co. Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation Dwarf

11. Industry or business None

MOTHER FATHER { 12. Name Samuel Wright  
13. Birthplace Ireland  
(City, town, or county) (State or foreign country)  
14. Maiden name Rebecca Lee  
15. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Archie M. Sumner

(b) Address Huyvasse Mo.

17. (a) Burial (b) Date thereof Jan. 10 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright Cemetery, Jonesburg, Mo.

18. (a) Signature of funeral director Hughes Martin

(b) Address Huyvasse Mo.

19. (a) Jan 9-40 (b) W. B. Nichols  
(Date received local registrar) (Registrar's signature)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature W. B. Nichols (M. D. or other) \_\_\_\_\_  
Address Huyvasse Mo. Date signed 1-9-40

WHILE FILLING IN—USE UNFADING BLACK INK—MAKE 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.

1-10351

SECRETARY

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 Hughes Manfieri  
Licensed Embalmer No. 2358  
P. O. Address AuxVale, 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.

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

1844  
Do not use this space.

1. PLACE OF DEATH

(a) County Callaway Registration District No. 102  
 (b) Township \_\_\_\_\_ Primary Registration District No. 4062 Registered No. \_\_\_\_\_  
 (c) City Amessee (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

Thomas Theodore Knight  
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED s  
 (Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 30 1881

7. AGE YEARS 38 MONTHS 0 DAYS 8  
 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as lawyer, 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)

FATHER  
 13. NAME

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

MOTHER  
 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 Jay 1949 C. B. Nichols  
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-8, 1940

22. I HEREBY CERTIFY, That I attended deceased from

19\_\_ to \_\_\_\_\_, 19\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_ Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Date of onset

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) C. B. Nichols, M. D.

(Address) Amessee

N. B.—Every item of information should be carefully supplied. AGE should be stated. SUFFICIENTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

