

Registration District No. 1878

Primary Registration District No. 4222

Registrar's No. 25-

1. PLACE OF DEATH:
(a) County Howard
(b) City or town Fayette
(c) Name of hospital or institution Lee Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Hospital #2 hr
(Specify whether
In this community _____
years, months or days) 60-3

3. (a) PRINT FULL NAME LLOYD LYNN WRIGHT
3. (b) If veteran, name war _____
3. (c) Social Security No. 495-09-0159

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Florence Wright
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased Sept. 30, 1886
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
53 5 10 hr. min.

9. Birthplace Nahata, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Painter

11. Industry or business _____

MOTHER FATHER
12. Name J. H. Wright, Sr.
18. Birthplace Marion, Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Hannah C. Sampson
15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Florence Wright

(b) Address Fayette, Mo

17. (a) Burial (b) Date thereof Mar. 12, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fayette City Cem

18. (a) Signature of funeral director J. P. McCarry

(b) Address Fayette, Mo

19. (a) Apr 5-1940 V. O. Bonham
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Howard
(c) City or town Fayette
(If outside city or town limits, write "RURAL")
(d) Street No. 402 Morrison
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March day 10
year 1940 hour 5 minute 20 AM.

21. I hereby certify that I attended the deceased from Dec.
_____, 1939, to March 10, 1940;
that I last saw him alive on March 9, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death
Skull Fracture (basal)
causing Cerebral Hemorrhage
Due to Fall at Home
Due to _____

Other conditions (Include pregnancy within 3 months of death)
No

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence March 9, 1940
(c) Where did injury occur? Fayette, Howard, Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
336 Home
While at work? No (Specify type of place) (e) Means of injury Fall

23. Signature J. H. Langdon (M. D. or other) M. D.
Address 100 E. Davis, Fayette Mo Date signed 3-14-40

WRITE PLAINLY—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.

REV. 8-17-33 I X1931

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed H-S-70

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..... *K.P.M. Crary*.....
Licensed Embalmer No. *31530*.....
P. O. Address. *Fayette, 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.