

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 160

I. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Hayes Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 36 hrs  
(Specify whether In this community 47 yrs 10 mo 26 days years, months or days)

3. (a) PRINT FULL NAME Shirley Morton Bright  
3. (b) If veteran, name war World War 3. (c) Social Security No. —

4. Sex MALE 5. Color or race White 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife — 6. (c) Age of husband or wife if alive — years  
7. Birth date of deceased 9 4 1892  
(Month) (Day) (Year)

8. AGE: Years 47 Months 10 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Boone County Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
12. Name William A Bright  
18. Birthplace Calloway Co. Mo  
(City, town, or county) (State or foreign country)  
14. Maiden name SALLIE CARTER BRIGHT  
15. Birthplace Boone County Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant H. H. Bright  
(b) Address Columbia Mo

17. (a) BURIAL (b) Date thereof 8-2-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Columbia Cemetery

18. (a) Signature of funeral director Perkins Funeral Co  
(b) Address Columbia Mo

19. (a) 8/2/40 (b) Allie Selby  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone  
(c) City or town Columbia  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3 miles N. of Columbia  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 1 year 1940 hour 9 minute 23 A.M.

21. I hereby certify that I attended the deceased from July 29 1940 to Aug 1 1940  
that I last saw him alive on July 31 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Rocky Mountain Spotted fever  
Duration 10 days

Due to Tick bite

Due to \_\_\_\_\_

Other conditions 44  
(Include pregnancy within 3 months of death)

PHYSICIAN  
Major findings None  
Of operations \_\_\_\_\_  
Of autopsy None  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Tick bite  
(b) Date of occurrence About July 20, 1940  
(c) Where did injury occur? On farm Boone Co. Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Yes Boone Mo.

While at work? on water (Specify type of place) (e) Means of injury Tick bite

23. Signature W. D. Dizon (M. D. or other) \_\_\_\_\_  
Address Columbia, Mo. Date signed 8-2-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 14 1942

---

---

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

*M. W. Whitehead*

Licensed Embalmer No.

*3893*

P. O. Address

*Calumet 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.