

32680

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31

Registration District No. 644

Primary Registration District No. 4555

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Granby
(If outside city & town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20
(Specify whether years, months or days)

In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Newton

(c) City or town Granby
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Sherman W. Wright

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edna Brand Wright

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov. 30, 1906
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>33</u>	<u>9</u>	<u>27</u>	_____ hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER

12. Name Jess Wright

13. Birthplace Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Keelan

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

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

(b) Address Granby, Mo.

17. (a) Burial (b) Date thereof 9-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Granby Cemetery

18. (a) Signature of funeral director Ed. C. Ulmer

(b) Address 1208 Garrison, Carthage, Mo.

19. (a) Sept 26-1940 (b) L. Keelans
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 26th
year 1940 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from Sept 1
1940 to Sept 26, 1940;
that I last saw him alive on Sept 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia J.B.

Due to _____

Due to _____

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

Major findings: _____

Of operations _____

Of autopsy _____

Duration 20 3/4

PHYSICIAN _____
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) _____

(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? _____

5-114
While at work? _____
(Specify type of place) (e) Means of injury

23. Signature R. E. Ralens (M. D. or other) _____
Address Granby Mo Date signed 9-27-40

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. 61

District File Number

1040-2223
OCT 15 1940

Date Filed

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.