

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37935
Registrar's No. 4533

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
909 East Linwood Blvd.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2
In this community Since 1908 (Specify whether years, months or days)

3. (a) PRINT FULL NAME Dr. Uriel S. Wright

8. (b) If veteran, name war - 8. (c) Social Security No. -

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Edna M. Wright 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Oct. 21, 1874
(Month) (Day) (Year)

8. AGE: Years 66 Months 1 Days 5 If less than one day hr. min.

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

10. Usual occupation Retired Physician

11. Industry or business

12. Name Dr. U. S. Wright

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

14. Maiden name Caroline Shafiroth

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

16. (a) Informant Mrs. Edna M. Wright

(b) Address 909 E. Linwood Blvd.

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

(c) Place: burial or cremation Fayette, Missouri

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) NOV. 27, 1940 (b) M. M. Craue
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 909 E. Linwood Blvd
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 26th
year 1940 hour 11 minute 20 A. M.

21. I hereby certify that I attended the deceased from July 15, 1940 to Nov 26, 1940
that I last saw him alive on Nov 26, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to _____

Other conditions GA
(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) Manner of injury _____

23. Signature George C. Lee (M. D. or other) _____
Address 6120 Wood Park Way Date signed 11/26/40

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

MOTHER PAYER

REC'D DEC 21 1940

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

11-3
Dr. George Lee
Professional Body

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 Joseph Hecker
Licensed Embalmer No. 3738
P. O. Address K. E. D. D.

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.