FILED JAN 25 1941

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

42420
Do not use this space.

1. PLACE OF DEATH
(a) County Dunklin Registration District No. 284
(b) Township Holcomb S Primary Registration District No. 5404B Registered No.
or
(c) City (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 Norma May Wright
(a) Residence, No. S St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Fem
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 12-1940

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
—	—	18	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, 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) Holcomb Mo

FATHER
13. NAME Clarence Wright
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER
15. MAIDEN NAME Armenda Eagan
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT (ADDRESS) Father Holcomb

18. BURIAL, CREMATION, OR REMOVAL
PLACE DATE 12-31 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Landers Funeral Home No Service

20. FILED 1-10 1941 J. A. Anderson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/30 1940

22. I HEREBY CERTIFY, That I attended deceased from 12/12 1941, to 12/30 1940
I last saw her alive on 12/27 1940. Death is said to have occurred on the date stated above, at 9 a.m.
The principal cause of death and related causes of importance were as follows:

Congenital Heart. Date of onset

Other contributory causes of importance: Pneumonia

157 C

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) [signature] M. D.
(Address) Holcomb Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should stat CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

X16805

RECEIVED
District Health Officer No. 2
District File Number 141-120
Date Filed 4/14/41

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 comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.