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JAN 25 1947 35  
Registration District No.

Primary Registration District No. 3034

Registrar's No. 106

1. PLACE OF DEATH:

(a) County Randolph  
(b) City or town Moberly  
(c) Name of hospital or institution: Wabash Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph  
(c) City or town Moberly  
(d) Street No. 309 E. Rollins  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME James O. Wright

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 491-07-2469

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

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Nov. 14<sup>th</sup> 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
60 1 14 hr. min.

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

10. Usual occupation Section hand

11. Industry or business Wabash RR

12. Name Silas Wright

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

14. Maiden name Mary Burch

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

16. (a) Informant Miss. Mary Wright

(b) Address Moberly Mo

17. (a) Burial (b) Date thereof Dec 30<sup>th</sup> 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Mahan and Son  
(b) Address Moberly Mo

19. (a) Dec 30-40 (b) Leah Williams  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 28<sup>th</sup>  
year 1940 hour 4 minute 15 am.

21. I hereby certify that I attended the deceased from Dec 6, 1940 to Dec 28, 1940  
that I last saw him alive on Dec. 28, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Disease

Due to Acute Hepatitis 1 mo.

Due to Acute Cholecystitis 1 mo.

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

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
925 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature P.S. Kwiatkowski (M. D. or other) \_\_\_\_\_  
Address Moberly, Mo Date signed 1/20/40

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

RECEIVED

District Health Officer No. 10

District File Number 1-415472

Date Filed JAN 16 1941

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**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.**