

FILED APR 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11374

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 86

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mississippi River
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution not in hospital
In this community 20 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion
(c) City or town Hannibal
(If outside city or town limits, write "RURAL")
(d) Street No. 1909 Chestnut
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

8. (a) PRINT FULL NAME Corwin Lynn 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 Lillie Wright 6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased December 12, 1885
(Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days 12 If less than one day hr. min.

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

10. Usual occupation stepfather

11. Industry or business

MOTHER FATHER { 12. Name Cyrus H. Wright
13. Birthplace Do not know Vermont
(City, town, or county) (State or foreign country)
14. Maiden name Anna Thomas
15. Birthplace Do not know Pennsylvania
(City, town, or county) (State or foreign country)

16. (a) Informant Lillie Wright

(b) Address Hannibal, Missouri

17. (a) Burial (b) Date thereof March 13, 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grand View Burial

18. (a) Signature of funeral director Ralph Schmidt
(b) Address Hannibal, Missouri

19. (a) March 14, 1941 (b) H. C. Fisher
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1940 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from Dec 24 Body
19—, to —, 19—;
that I last saw his Body - Mar-11, 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death Death by Drowning

Due to
Due to
Other conditions (Include pregnancy within 3 months of death) 11/11/39

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) Injury occur in or about home, on farm, in industrial place, in public place?
14 X X

While at work? (Specify type of place) (e) Means of injury

23. Signature H. E. Lealwell CORONER
Address NEW London - Mo Date signed 3/12/41

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

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

183-
99

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.....

Ray P. Schwartz

....., Registered Apprentice No.

working under my personal supervision.

Signed

Ray P. Schwartz

Licensed Embalmer No. *17650*

P. O. Address *Hannibal, 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.

In this death certificate we note the date of death is given as May 24, 40. Are there witnesses to this drowning? We are required to have the date of death correct and as this body was not found until Mar. 11, 41 we wish to know if the death date given is correct?

May we have the place this drowning took place? Public lake, river, etc.

Could you give us the information as to how deceased was identified when found?

We would appreciate all information you can give us to complete our record in this department.

Thank you

1941

S-11374

Please write requested information
on face of supplemental and return
in the enclosed franked envelope.
Thank you.

A handwritten signature in cursive script that reads "Harry F. Parker". The signature is written in dark ink and is positioned above the typed name.

Harry F. Parker, M. D.

Special Agent, Bureau of the Census

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 11374
Registrar's No. 86

Registration District No. 549

Primary Registration District No. 3029

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

1. PLACE OF DEATH:

(a) County Madison
(b) City or town Hannibal
(If outside city or 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 _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Carwin Lynn Knight
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 54 Months 5 Days 12 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 12. Name
13. Birthplace (City, town, or county) (State or foreign country)

{ 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) Yes
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 24
year 1940 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____

that I last saw him alive on Mar 11 and that death occurred on the date and hour stated above.

Immediate cause of death Date of death as given
was last time deceased was seen alive. Duration

No witnesses to actual drowning.

All dates correct.

Place of drowning--Mississippi River.

Due to Identified by clothing and gold watch with name inside.

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 182

Of autopsy _____

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?

While at work? (Specify type of place) (e) Means of injury

23. Signature H. E. Caldwell (M. D. or other) Carwin

Address New London Ark

DUPLICATE

1941
5-11374

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, fact should be so stated above.

S. N. 41
1952

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

ROWENA MOORE

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
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Registrar's No.

1. PLACE OF DEATH:

(a) County Marion

(b) City or town Hannibal
(If outside city or 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 _____
(Specify whether _____)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

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

(e) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Corwin Lynn Wright

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased _____
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 24
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
24 5 12 _____ hr. _____ min.

Immediate cause of death Death by drowning

Due to _____

Due to _____

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____
(City, town, or county) (State or foreign country)

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

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence May 24, 1940

(c) Where did injury occur? Hannibal Marion Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Mississippi River jumped from
Bridge into water (Specify type of place) (e) Means of injury _____

23. Signature C. M. Justice (M. D. or other) _____
Address Hannibal 24. Date signed July 2 1941

SUPPLEMENTARY

MOTHER FATHER