

STANDARD CERTIFICATE OF DEATH

State File No. 31005

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. 265

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia Mo.  
(c) Name of hospital or institution: Boone Co. Hospital  
(d) Length of stay: In hospital or institution 3 hr.

3. (a) PRINT FULL NAME Howard Jessie Wright

3. (b) If veteran, name was Harold Star 3. (c) Social Security No.

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced M. 1

6. (b) Name of husband or wife Elizabeth Wright 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased May 15 - 1871

8. AGE: Years 70 Months 4 Days 15 hr. 15 min.

9. Birthplace Manchester Mo.

10. Usual occupation Dr. M.D.

11. Industry or business M.D.

12. Name John Wright

13. Birthplace Unknown 9

14. Maiden name Hanna Turner

15. Birthplace Unknown 0

16. (a) Informant Gerald Wright (b) Address 1110 N. Elm St. Crestwood

17. (a) Burial, cremation, or removal (b) Date thereof 10/13/41 (c) Place: burial or cremation Merrill, Ia.

18. (a) Signature of funeral director R. O. Willett (b) Address Columbia Mo.

19. (a) 10/1/41 (b) Allie Selby

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Polk 999  
(c) City or town Des Moines 0  
(d) Street No. 1632 47th Ave. 2  
(e) If foreign born, how long in U. S. A.?

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30 day Sept year 1941 hour 1 minute 40 P. M.

21. I hereby certify that I attended the deceased from 9-30-41 to 9-30-41, 1941; that I last saw him alive on 9-30-41, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death Concussion of Brain 2 hr

Due to

Due to Auto accident

Other conditions (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) Yes - V  
(b) Date of occurrence 9-30-41 010

(c) Where did injury occur? Highway 40  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public Highway

While at work No (Specify type of place) (e) Means of injury

23. Signature D. O. Robceod (M. D. or other) 6 M D  
Address 1680 10th Date signed 9/20/41

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

OCT 16 1941

OCT 27 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 *Lymon J. Sprinkle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia, 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 31005

Registration District No. 73

Primary Registration District No. 3006

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Boone  
(b) City or town Columbia  
(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 Howard J. 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 May 15 1892  
(Month) (Day) (Year)

8. AGE: Years 70 Months 4 Days 9 If less than one day \_\_\_\_\_ min.

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 \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 11/12/41 (b) Allie Selby  
(Date received local registrar) (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)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to concussion of Brain  
auto accident

Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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) yes - accident

(b) Date of occurrence 9-30-41

(c) Where did injury occur? US Highway #140 Boone Co  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Highway 40

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

23. Signature Thomas J. Selby M.D. or other \_\_\_\_\_

Address Columbia Date signed 11-14-41

SUPPLEMENTARY

WHILE IN FULL USE OF UNFADING INK—MAKE A PERMANENT RECORD

MAR 2 1941

NOV 19 1941

1941  
S-31005

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