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5-17-39  
X32873

FILED FEB 9 1943

State File No. ....

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 227

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe  
(If outside city or town limits, write "RURAL," and name of township)

(c) Name of hospital or institution:  
Chillicothe Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days  
(Specify whether years, months or days)

In this community 15 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

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

(d) Street No. 401 South Washington St.  
(If rural, give location)

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

3. (a) PRINT FULL NAME ROBERT BROOKS WRIGHT

3. (b) If veteran, name war..... 3. (c) Social Security No. 487-20-1329

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

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

7. Birth date of deceased Oct. 30 1925  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>17</u>	<u>2</u>	<u>22</u>	hr. min.

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

10. Usual occupation Student

11. Industry or business Clerk in Groceries Store

12. Name Robert D. Wright

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

14. Maiden name Nettie M. Brooks

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

16. (a) Informant Mrs R. D. Wright

(b) Address Chillicothe, Missouri.

17. (a) Wheeling, Mo. (b) Date, thereof 1-24-'43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wheeling Cemetery

18. (a) Signature of funeral director F. B. Norman Co.

(b) Address Chillicothe, Missouri.

19. (a) January 23 - 1943 Lowell Perry  
(Date received local Registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 22 year 1943 hour 4:00 minute A. M.

21. I hereby certify that I attended the deceased from Jan 7 1943, to Jan 22 1943; that I last saw him alive on Jan 21 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Abscess of brain. Duration 17 1/2 days

Due to Abscess of nose Duration 14 1/2 days

Due to.....

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN

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?..... (Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature W. W. ... (M. D. or other).....

Address Chillicothe, Mo. Date signed Jan 23, 1943

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

MOTHER FATHER

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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.....  
..... E. R. Norman ....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... ER Norman .....

Licensed Embalmer No..... 2374 .....

P. O. Address..... Chillicothe, 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, fact should be so stated above.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2788

Registration District No. 187

Primary Registration District No. 3040

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

1. PLACE OF DEATH:

(a) County Livingston

(b) City or town Chillicothe  
(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 Robert Brooks 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 S

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased 001 30 19  
(Month) (Day) (Year)

8. AGE: Years 17 Months 2 Days \_\_\_\_\_ 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) \_\_\_\_\_ (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)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I observed him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death abscess of brain

Due to abscess of nose 14 day  
probable staphylococcus

Due to not tuberculous or malignant

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) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature Chillicothe Mo (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed 8/4/43

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

SUPPLEMENTARY 2

