

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **17214**
 Registrar's No. **2112**

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
 (a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Kansas City General Hospital **O**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 weeks
(Specify whether
 In this community 27 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Jackson **48**
 (c) City or town Kansas City **3**
(If outside city or town limits, write "RURAL")
 (d) Street No. 3421 East 12 St **8**
(If rural, give location) **0**
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Alfred Wright
 (b) If veteran, name war None
 (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month May day 5
 year 1943 hour 10 minute A M.

4. Sex Male **O** 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 (b) Name of husband or wife Ida May Wright
 (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased March 4 1878
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____ **19**;
 _____ **19**;
 that I last saw him Deputy Coroner
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>65</u>	<u>2</u>	<u>1</u>	_____ hr. _____ min.

Immediate cause of death acute circulatory failure
 Due to operative procedure
 Due to for previously fractured left hip

9. Birthplace Illinois
(City, town, or county) (State or foreign country)
 10. Usual occupation Retired Farmer

Other conditions 1869
(Include pregnancy within 3 months of death)
 Major findings: Of operations _____
 Of autopsy See above

MOTHER FATHER
 11. Industry or business _____
 12. Name Andrew Wright
 13. Birthplace No Record **9**
(City, town, or county) (State or foreign country)
 14. Maiden name Melinda Snell
 15. Birthplace No record **9**
(City, town, or county) (State or foreign country)

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) Accident 123
 (b) Date of occurrence April 21 1943
 (c) Where did injury occur? Kansas City Jackson Mo.
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home

16. (a) Informant Ida May Wright
 (b) Address 3412 East 12 St,
 17. (a) Burial (b) Date thereof May 7 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Forest Hill Cem.
 18. (a) Signature of funeral director Mrs C. L. Forster
 (b) Address 918 Brooklyn.
 19. (a) 5-6-43 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

While at work No (Specify type of place)
 (c) Months of injury 1
 23. Signature Dr. E. C. Usher M.D. or _____
 Address 23rd M & 1st Coy Date signed 5/7/43

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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 Wenzel C. Browning

Licensed Embalmer No. 2724

P. O. Address K. P. No

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.