

Registration District No. 59

Primary Registration District No. 4094

Registrar's No. 9

1. PLACE OF DEATH:

(a) County Cass
(b) City or town Cardon city
(c) Name of hospital or institution: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Home years, months or days

8. (a) PRINT FULL NAME Elizabeth Ruth Wright

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

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

6. (b) Name of husband or wife Mrs. Wright 6. (c) Age of husband or wife if alive 69 years
John Wright Sept. 5 1874
Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 69 Months 4 Days 15 If less than one day hr. _____ min.

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

10. Usual occupation House Wife

MOTHER FATHER

12. Name Lenard Fritz Penn. /
13. Birthplace Cardon City, Mo. (State or foreign country)
14. Maiden name atherans. McCarron
15. Birthplace Penn. (City, town, or county) (State or foreign country)

16. (a) Informant Miss Ida Fritz
(b) Address arden City, MO.

17. (a) Burial (b) Date thereof Jan 21st 44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation arden City, Cem.

18. (a) Signature of funeral director J. H. ...
(b) Address ...

19. (a) Jan. 23, 1944 (b) Margaret ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
(c) City or town Cardon City
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A? x 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day Jan-19-44
year 1944 hour 3 AM minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____
that I last saw him alive on January 19 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage
Due to arteriosclerosis

Due to _____
Other conditions J. Za
(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) _____
(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) (c) Means of injury _____

23. Signature Frank B Ellis (M. D. or _____)
Address Cardon City Date signed Jan 19-44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

STATEMENT BY LICENSED EMBALMER

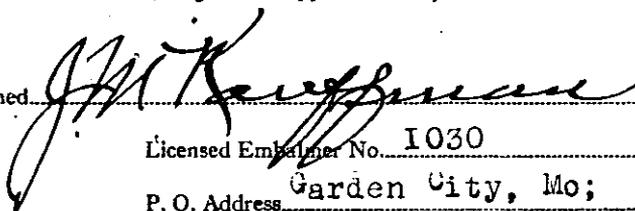
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

J.M. Kauffman

....., Registered Apprentice No. **1080**

working under my personal supervision.

Signed.....



Licensed Embalmer No. **1030**

P. O. Address **Garden City, Mo;**

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.