

FILED MAR 13 1944

Registration District No. _____

Primary Registration District No. **45 12**

Registrar's No. **34**

1. PLACE OF DEATH:

(a) County **Sullivan**
(b) City or town **Newtown**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **D. Dale Hospital**
(If not in hospital or institution, write street number & location)
(d) Length of stay: In hospital or institution **few days**
(Specify whether years, months or days) **22 yrs.**

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME **Alonzo Anders Wright**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **15** year **1944** hour **5:30** minute **A.** M.

21. I hereby certify that I attended the deceased from **Jan 1** 19**39**, to **Feb 15** 19**44**
that I last saw him alive on **Feb 15** 19**44**
and that death occurred on the date and hour stated above.

4. Sex **male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced, **widowed**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: **7** (Month) **6** (Day) **1851** (Year)

Immediate cause of death: **Cardiac failure**
Due to **Uremic poisoning**
Due to _____

8. AGE: Years **92** Months **6** Days **9** If less than one day hr. _____ min.

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

10. Usual occupation **Blacksmith**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph Wright**
13. Birthplace **N. Y.**
(City, town, or county) (State or foreign country)
14. Maiden name **Leah Altman**
15. Birthplace **Penn.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bessie Wright**
(b) Address **Newtown, Mo.**

17. (a) **removal** (b) Date thereof **Feb 17-44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Sibley, Mo.**

18. (a) Signature of funeral director **Judd Spame**
(b) Address **Newtown**

19. (a) **Feb 21 1944** (b) **Mrs John Ford**
(Date received local registrar) (Registrar's signature)

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

Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury **2**

23. Signature **Y. Dale** (M. D. or other) **D.O.**
Address **Newtown Mo** Date signed **2/16/44**

13 5 3

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

RECEIVED

District Health Officer No. 10

District File Number 3-4-570

Date Filed MAR 10 1944

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

T. Howard Kulef

Licensed Embalmer No. 3245

P. O. Address Newtown

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.

Registration District No. 048

Primary Registration District No. 4512

1. PLACE OF DEATH:

(a) County Sullivan

(b) City or town Newtown
(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 Alonzo Andrew Wright

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb
year 1944 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 cardiac failure Duration _____

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

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

7. Birth date of deceased July (Month) 1908 (Day) (Year)

8. AGE: Years 92 Months 6 Days _____ Unless than one day _____ min.

9. Birthplace Ohio
(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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

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

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

Due to Uremic poisoning

Due to Chronic Nephritis

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)

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

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

23. Signature G. H. Hale (M. D. or other) DR
Address Newtown Mo Date signed _____

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

SUPPLEMENTARY

8501