

S. No. 2
1-5-42
15-17-39
X 32873

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14501

State File No. _____

FILED APR 20 1944

Registration District No. 17

Primary Registration District No. 3016

Registrar's No. 87

1. PLACE OF DEATH:

(a) County Cole
(b) City or town Jefferson City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Mo. Penitentiary Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 16 days (Hosp)
(Specify whether
In this community 13 months
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cole
(c) City or town Jefferson City
(If outside city or town limits, write "RURAL")
(d) Street No. Mo. State Penitentiary
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country. O

3. (a) PRINT FULL NAME James Wright

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

4. Sex Male 5. Color or race Negro 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 March 3, 1903
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 1 6 _____ hr. _____ min.

9. Birthplace Not Known (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business Common Labor

12. Name Not Known

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 Mo. State Penitentiary records
(b) Address Jefferson City, Mo.

17. (a) Removal (b) Date thereof 4/11/44
(Method, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jefferson Mo

18. (a) Signature of funeral director Thermal Richter
(b) Address Jefferson City, Mo.
19. (a) 4-11-44 (b) Thermal Richter
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9th
year 1944 hour 1:45 minute _____ P. M.

21. I hereby certify that I attended the deceased from Mar. 21,
1944 to April 9th., 1944
that I last saw him alive on April 9th., 1944
and that death occurred on the date and hour stated above.

Immediate cause of death
Agonal hypoxia due to asphyxia with
probable causes of
poor ventilation treatment
and 2 attacks of suffocation

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

Major findings:
Of operations _____
Of autopsy _____

Duration
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)
(e) Means of injury _____

23. Signature Thermal Richter (M. D. or other) M. D.
Address Jefferson Date signed 4/9/44

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

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RECEIVED

District Health Officer No. 9,

District File Number _____

Date Filed 4-18-44

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 Sylvester D. Delle
Licensed Embalmer No. 4321

P. O. Address Jefferson City, 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.