

FILED JUL 20 1944
Registration District No. 147

Primary Registration District No. 3008

14
2

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

1. PLACE OF DEATH: Calloway

(a) County Calloway

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

(c) Name of hospital or institution: State Hospital No. 2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4-5-16
(Specify whether years, months or days)

In this community same

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lincoln

(c) City or town Troy 14
(If outside city or town limits, write "RURAL") 1

(d) Street No. 2
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME DANIEL WRIGHT

3. (b) If veteran, name war DK.

3. (c) Social Security No. DK.

20. DATE OF DEATH: Month June day 12
year 1944 hour 4 minute 30 P. M.

21. I hereby certify that I attended the deceased from June 1
1944, to June 12, 1944
that I last saw him alive on June 12, 1944
and that death occurred on the date and hour stated above.

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: unknown
(Month) (Day) (Year)

Immediate cause of death: General Paralysis Insane

Due to _____

Due to _____

8. AGE: Years 75 Months ? Days _____ If less than one day _____ hr. _____ min.

Other conditions: Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

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

10. Usual occupation laborer

11. Industry or business _____

12. Name DK

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

14. Maiden name DK

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

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? _____

16. (a) Informant Records State Hosp No 1

(b) Address Fulton Mo

17. (a) Burial (b) Date thereof June 15 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Troy Missouri

18. (a) Signature of funeral director Wayne M. Coy

(b) Address Troy Mo

19. (a) 6-15-44 (b) Joan Moravichoff
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)

(c) Means of injury MI

23. Signature R. E. Shoult (M. D. or other) MI

Address Fulton Mo Date signed 6/12/44

RECEIVED

District Health Officer No. 9

District File Number

Date Filed 7-19-44

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 *Not Embalmed*

....., Registered Apprentice No.
working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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.