

Registration District No. **209**

Primary Registration District No. **3043**

**1. PLACE OF DEATH:**

(a) County Marion  
(b) City or town Hannibal  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Levering Hospital  
(If not in hospital or institution, write street number or location) 0  
(d) Length of stay: in hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Shelby  
(c) City or town Shelbyville  
(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**

William Wright

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Mary Wright 6. (c) Age of husband or wife if alive 70 years  
7. Birth date of deceased May 20, 1873  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	71	6	17	hr. _____ min.

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name John Wright  
13. Birthplace Indiana (City, town, or county) (State or foreign country)  
14. Maiden name Cynthia Young  
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Wright  
(b) Address Shelbyville Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1944 (Month) (Day) (Year)  
(c) Place: burial or cremation I. O. O. F. Cemetery Shelbyville

18. (a) Signature of funeral director Wm. M. Smith  
(b) Address 902 Broadway Hannibal Mo

19. (a) 12-21-44 (Date received local registrar) (b) R. H. Connor (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month December day 16 year 1944 hour 3 minute 00 A. M.

21. I hereby certify that I attended the deceased from Dec 14, 1944 to Dec 15, 1944  
that I last saw him alive on Dec 15, 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death Apoplexy, Cerebral Duration 1 week

Due to arterio sclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 83d!

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? \_\_\_\_\_

(Specify type of place) While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Wm. M. Smith (M. D. or other) Address Hannibal Mo Date signed 12-20-44

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

4  
3  
4

1146

**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 *George T. Bond*

Licensed Embalmer No..... 4373

P. O. Address... Hannibal Missouri

**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.**