No. 2
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5-17-39
1 X35597

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

Lewellyn

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 14 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14295

State File No.

Registration District No. 218

Primary Registration District No. 3054

Registrar's No.

1. PLACE OF DEATH:

(a) County Pike

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

(c) Name of hospital or institution: Pike Co Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day (Specify whether)

In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Pike

(c) City or town Annada
(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 MICHAEL EDWARD WRIGHT

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race White

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 8/15 44 (Month) (Day) (Year)

8. AGE: Years 0 Months 7 Days 17 If less than one day ..... hr. ..... min.

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

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Robert Eugene Wright
13. Birthplace Cyrene Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Donna Louise Hemphill
15. Birthplace Pillsfield Ill (City, town, or county) (State or foreign country)

16. (a) Informant Mrs R E Wright Mother

(b) Address Annada Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4-45 (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Mo

18. (a) Signature of funeral director F C Haly

(b) Address Louisiana Mo

19. (a) Apr 2-45 (Date received local registrar) (b) F C Haly (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 2 year 1945 hour 12 minute 30 A M.

21. I hereby certify that I attended the deceased from 4-1, 1945 to 4-1-, 1945 that I last saw him alive on 4-1-, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia — Duration 3 wks

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Major findings:
Of operations none

Of autopsy none

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) none

(b) Date of occurrence none

(c) Where did injury occur? none (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? none (Specify type of place)

While at work? none (e) Means of injury none

23. Signature Charles P. Lewellen (M. D. or other)

Address Louisiana Mo Date signed 4/2/45

1169

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 5-45-781
Date Filed MAY 10 1945

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 George O. Wagner, Registered Apprentice No. ....., working under my personal supervision.

Signed George O. Wagner

Licensed Embalmer No. 3973

P. O. Address Louisiana, 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.

No. 2B
(—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 9

1. PLACE OF DEATH:
(a) County Pike
(b) City or town Louisiana
(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 years, months or days) In this community

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 Michael E. Wright
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S.
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Aug 4 1944 (Month) (Day) (Year)
8. AGE: Years 0 Months 3 Days 12 If less than one day hr. min.
9. Birthplace (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to Pneumonia, Bronchial	
Due to Typhoid	
Due to Primary Canal	
not known.	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 10 M

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 Charles F. Lewellen M.D. (M. D. or other)
Address Louisiana, Mo. Date signed 8/13/45

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

14295