

Registration District No. 279

Primary Registration District No. 5957

Registrar's No. 17

1. PLACE OF DEATH

(a) County Pike  
(b) City or town Galva mo  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution no  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Pike  
(c) City or town Galva  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0  
(If rural, give location)  
(e) Citizen of foreign country? 0  
(Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Roxie Wright

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

4. Sex Female 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 25 June 1885  
(Month) (Day) (Year)

8. AGE: Years 63 Months 1 Days 23 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Galva mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Teaching School

11. Industry or business

12. Name Thompson Wright  
13. Birthplace Galva mo  
(City, town, or county) (State or foreign country)  
14. Maiden name Florence Burks  
15. Birthplace Galva mo  
(City, town, or county) (State or foreign country)

16. (a) Informant A W Turpin  
(b) Address Galva mo

17. (a) Burial (b) Date thereof Aug 19 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Galva Cemetery

18. (a) Signature of funeral director Edith M. Patton

(b) Address Galva mo

19. (a) Aug 22 1945 (b) Maudie M. Patton  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 17  
year 1945 hour 4 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculosis of the lungs  
Duration \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy 13A

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 3

23. Signature Edith M. Patton  
Address Galva mo Date signed 8-17-45

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

MOTHER FATHER

1364

489

2881

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 Norman E. Gooch

Licensed Embalmer No. 2342

P. O. Address: Galva 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.

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. Sept  
Registrar's No. 17Registration District No. 279 Primary Registration District No. 5957

## 1. PLACE OF DEATH:

(a) County Pike  
(b) City or town Prineville, Colia  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: July

(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)3. (a) PRINT  
FULL NAMERoxie Wright3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_4. Sex F 5. Color or race w 6. (a) Single, widowed, married,  
divorced S6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years7. Birth date of deceased June 25  
(Month) (Day) (Year)8. AGE: Years 63 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_9. Birthplace mo  
(City, town, or county) (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) \_\_\_\_\_ (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) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pike  
(c) City or town Colia  
(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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year 1965 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

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

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline  
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which death  
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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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

S-28204