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FILED NOV 17 1945

Registration District No. _____ Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**

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

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

(d) Length of stay: In hospital or institution **12 hours 2 days**
(Specify whether _____)

In this community **2 years**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**

(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")

(d) Street No. **4701 Wyoming**
(If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **Dorothy Lee WRIGHT**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **none**

4. Sex **Female** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Geo. G. Wright**

6. (c) Age of husband or wife if alive **23** years

7. Birth date of deceased **Jan. 5, 1925**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
20	9	26	_____ hr. _____ min.

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

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER

12. Name **Herman A. Wellman**

13. Birthplace **Carrolton Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Bulah E. McReynolds**

15. Birthplace **Mercier Mo.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. Geo. G. Wright**

(b) Address **4701 Wyoming Kansas City Mo.**

17. (a) **Burial** (b) Date thereof **11/4/45**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Carrolton, Mo.**

18. (a) Signature of funeral director **Melody-McGilley-Eylar**

(b) Address **1800 Linwood Blvd. K.C. Mo.**

19. (a) **10-31-45** (b) **Alredine Holmes**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **31** th
year **1945** hour **1** minute **35** A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
CORONER

that I last saw h. _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: **Bronchitis pneumonia (Bilateral)**

Due to **Stomach contents Removed for analysis.**

Due to **6/2 month (male) child born before death (Dead)**

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

Major findings: Of operations _____

Of autopsy **yes - REQUESTED**

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 **3rd party**

23. Signature **Jamie Walker** (M.D. or other) _____
Address **1824 2nd St** Date signed **10-31-45**

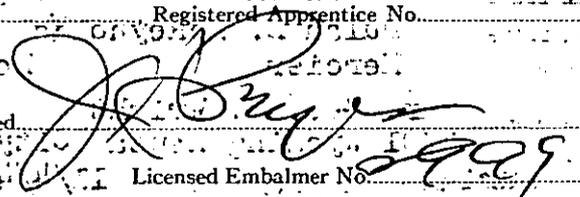
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Nov
Registrar's No. 4493

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas city
(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 _____)

In this community _____ (Specify whether _____)
years, months or days
3. (a) PRINT FULL NAME Dorothy L Wright
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Jan 5 (Month) (Day) (Year)

8. AGE: Years 20 Months _____ Days _____ If less than one day _____ hr. _____ min. mo
9. Birthplace _____ (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) _____ (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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Jackson
(c) City or town K C (If outside city or town limits, write "RURAL")
(d) Street No. 4701 Wyoming (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1945 Hour _____ minute 35 A M.
21. I hereby certify that I attended the deceased from _____ to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Broncho Pneumonia (Belateral)
Due to Stomach contents removed for analysis
Due to 6 1/2 Month (Male) Child born before death. (Dead)
Other conditions _____ (Include pregnancy within 6 months of death)

PHYSICIAN _____
Major findings: _____
Of operations _____
Of autopsy Yes (as above)
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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

32970

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 4493

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

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Research Hosp
(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

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 Dorothy Lee Wright

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

4. Sex _____ 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 10-31-45 (b) Geraldine Holmes
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 31 Year 1945 hour _____ minute 35 a. M.

21. I hereby certify that I attended the deceased from _____ 19____; that I first saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

broncho pneumonia
bilateral

Due to 6 1/2 mo. male child born before death (Dead)

Due to no poison or foreign matter found in stomach

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

Major findings: Of operations _____ 141-2

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)
(b) 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 James C. Walker M. D. or other? _____
Address 1424 Prof. Bldg. Date signed 10-31-45

SUPPLEMENTARY

32970