

S. No. 2
M-5-43
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
FILED JAN 14 1946 STANDARD CERTIFICATE OF DEATH

Dr. Fitch
State File No. **41290**
Registrar's No. **1083**

Registration District No. **128** Primary Registration District No. **1000**

1. PLACE OF DEATH:
(a) County **Greene**
(b) City or town **Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Burge Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 Months**
In this community **77 Years** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Greene**
(c) City or town **Rural Springfield**
(If outside city or town limits, write "RURAL" and name of township)
(d) Street No. **Route # 6**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Solom Wright**
3. (b) If veteran, name war **No** 3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Dec.** day **27**
year **1945** hour **4** minute **30p.** M.
21. I hereby certify that I attended the deceased from
4-1, 19 **45** to **12-27**, 19 **45**
that I last saw him alive on **12-27**, 19 **45**
and that death occurred on the date and hour stated above.

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **Annie Wright** 6. (c) Age of husband or wife if alive **Dec.** years
7. Birth date of deceased **Oct. 16 1868**
(Month) (Day) (Year)

Immediate cause of death
1. Angina - Rupt. Vascular
Thromb.
Duration **6-8 hrs.**

8. AGE: Years **77** Months **2** Days **11**
If less than one day **1 hr.** min.

Due to _____
Due to _____

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

Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **Jesse Wright**
13. Birthplace **W. Va. Tenn.**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary Frances Weaver**
15. Birthplace **W. Va. Tenn.**
(City, town, or county) (State or foreign country)

PHYSICIAN
Underline the cause to which death should be charged statistically.
1310

16. (a) Informant **Tom Wright**
(b) Address **Springfield, Mo.**

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? _____

17. (a) Burial (b) Date thereof **12/30/45**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Clear Creek**

18. (a) Signature of funeral director **H.H. Lonmeyer**
(b) Address **Springfield, Mo.**
19. (a) 12-2845 (b) **or W. Handley**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (c) Means of injury _____
23. Signature **Max Fitch** (M. D. or other) **M.D.**
Address **Springfield, Mo.** Date signed **12-28-45**

982 (Licensed Embalmer's Statement on Reverse Side)

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

9
2
6

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 *Walter E. Hamble*

Licensed Embalmer No. *3808*

P. O. Address *Spring Hill, TN*

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.