

No. 2
M-5-43
7-5-17-39
P I X3667

FILED MAR 27 1946

Registration District No. **149**

Primary Registration District No. **1002**

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

8704

1. PLACE OF DEATH: **Jackson**
 (a) County **Kansas City**
 (b) City or town **Kansas City**
 (c) Name of hospital or institution: **513 West 31st St.**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **XX**
 In this community **lifetime**
 years, months or days

3. (a) PRINT FULL NAME **MRS. JOSEPHINE A. WRIGHT**
 3. (b) If veteran, name war **XX**
 3. (c) Social Security No. **None**

4. Sex **Fe /**
 5. Color or race **Wh**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **Clarence Wright**
 6. (c) Age of husband or wife if alive **73** years
 7. Birth date of deceased **July 30 1875**
 (Month) (Day) (Year)

8. AGE: Years **70** Months **7** Days **9**
 If less than one day hr. min.

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

10. Usual occupation **At Home**

11. Industry or business
 12. Name **D. A. Hartman**
 13. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)
 14. Maiden name **No record**
 15. Birthplace **Indiana**
 (City, town, or county) (State or foreign country)

16. (a) Informant **Clarence Wright**
 (b) Address **513 West 31st St.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **3-12-46**
 (Month) (Day) (Year)
 (c) Place: burial or cremation **Mt. Moriah**

18. (a) Signature of funeral director **J.W. Wagner**
 (b) Address **Kansas City, Mo.**

19. (a) **3-12-46** (Date received local registrar)
 (b) **Sheraldine Holmes** (Registrar's signature)

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. **513 West 31st St.**
 (If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **Mar.** day **9th**
 year **1946** hour **6:** minute **30 A.**

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 **Coronary Arterio sclerosis**
 Due to _____
 Due to _____

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

PHYSICIAN
 Major findings: **gfa**
 Of operations _____
 Of autopsy _____
 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 **A.E. Usher** (M.D. or D.V.M.)
2800 Main Address Date dictated **3/11/46**

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..... *Alvin R Hunschild*

- - Licensed Embalmer No..... *4159*

P. O. Address..... *Hawson City 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.