

1. PLACE OF DEATH:
(a) County Moniteau County
(b) City or town California
(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 _____ years, months or days

3. (a) PRINT FULL NAME ALICE DELORIS WRIGHT

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

4. Sex ♀ 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Steve Wright 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Oct. 18 1862
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
83 9 4 hr. min.

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name Jane Atkinson

13. Birthplace Don't know
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Martin

15. Birthplace Don't know
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Leonard Halford

(b) Address California Mo.

17. (a) Burial (b) Date thereof 7-23-1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Masonic Cem Springfield

18. (a) Signature of funeral director Henry E. Hiltbrand

(b) Address California Mo.

19. (a) 7-23-46 (b) H.R. Popejoy
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Moniteau
(c) City or town California
(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 July day 22
year 1946 hour 11 minute 59 a. M.

21. I hereby certify that I attended the deceased from June 12 1946 to July 22 1946
that I last saw her alive on July 18 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Massive cerebral hemorrhage

Due to vascular degenerative changes - arteriosclerosis

Due to _____

Other conditions Hemiplegia
(Include pregnancy within 3 months of death) 7 yrs

Major findings: Multiple ulcerative intestinal lesions

Of operations: None

Of autopsy af 70

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 0

23. Signature J. P. Burke, Jr. (M. D. or other) _____
Address California, Mo Date signed 7/23/46

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

RECEIVED
District Health Officer No. 9,
District File Number J-46-114
Date Filed 8-8-76

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..... *Hugh E Williams*.....

Licensed Embalmer No..... *3537*.....

P. O. Address..... *California 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.