

y. S. No. 2
DOM-5-43
Rev. 5-17-39
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34525

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. 297 Primary Registration District No. 6020 Registrar's No. 100

1. PLACE OF DEATH:
(a) County Ray County.
(b) City or town Rural Crooked River.
(c) Name of hospital or institution: 3
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community Life Time (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Carroll
(c) City or town Norborne, Missouri.
(d) Street No. East 4 Street.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of ~~husband~~ wife Wife
Hellen Wright. 6. (c) Age of ~~husband~~ or wife if
alive _____ years
7. Birth date of deceased Nov. 1, 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 II 4 hr. XX min.

9. Birthplace Carroll County Missouri.
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer, And Stockman.

11. Industry or business _____
12. Name Martin VanBurn Wright.
13. Birthplace Green Castle Indiana.
(City, town, or county) (State or foreign country)
14. Maiden name Fleoba Ann Goodson.
15. Birthplace Carrollton County Missouri.
(City, town, or county) (State or foreign country)

16. (a) Informant T. O. Wright
(b) Address Norborne, Mo.
17. (a) Burial (b) Date thereof 10/7/1946
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Fairhaven C. Norborne.

18. (a) Signature of funeral director John G. Ditch
(b) Address Norborne, Missouri.
19. (a) 10/6/1946 (b) Mabel Jackson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 10-7 day 1946
year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from 10-4-46
19 _____ 19 _____
that I last saw him alive on 10-4-46
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris
Due to occlusion
Due to _____

Other conditions _____
(Include pregnancy within 5 months of death)
Major findings:
Of operations _____
Of autopsy 0413

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 Be. Rose (M. D. or other)
Address Norborne Mo. Date signed 10-6-46

Duration 30 min.
PHYSICIAN
Underline the cause to which death should be charged statistically.

273 (Licensed Embalmer's Statement on Reverse Side)

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

34525

RECEIVED

District Health Officer No. 8.

District File Number _____

Date Filed 10-19-46

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 Me

_____, Registered Apprentice No. _____
working under my personal supervision.

Signed John J. Deitch

Licensed Embalmer No. 3654

P. O. Address Norborne 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.