

S. No. 2
-12-45
5-17-39
PI X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16794
Registrar's No. 4

Registration District No. 5655

Primary Registration District No. 5655

FILED JAN 5 1947

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

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 277 days
(Specify whether years, months or days)

In this community 277 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Ira Noel 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 or wife Anna Wright

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

7. Birth date of deceased January 17 1900
(Month) (Day) (Year)

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

46 11 28 hr. min.

9. Birthplace Fordland Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business

MOTHER FATHER { 12. Name J. F. Wright

13. Birthplace Fordland Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Forbes

15. Birthplace Fordland Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant E. McMichael, Record Clerk

(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Removal (b) Date thereof Jan 10 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grave

18. (a) Signature of funeral director Gay H. Mentore

(b) Address Crane

19. (a) 1-11-47 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone

(c) City or town Crane
(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 Jan day 10th
year 1947 hour 4:45 minute A M.

21. I hereby certify that I attended the deceased from Apr. 8, 1946 to Jan 10, 1947
that I last saw h. in live on Jan 10, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Hemorrhage

Due to Pulmonary Tuberculosis Abt. 7 yrs.

Other conditions Diabetes mellitus Unknown
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy 138

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 _____

23. Signature Roy W. Dickman (M. D. or other) _____

Address Mt. Vernon, Mo. Date signed 1-10-47

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RECEIVED
District Health Officer No. 6,
District File Number 147-111
Date Filed JAN 14 1947

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

Lucy H. Montox

Licensed Embalmer No. 3827

P. O. Address *Cross 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.