

Registration District No. **128** Primary Registration District No. **2000**

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: **St. John Hosp.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1 Day**
(Specify whether years, months or days)

In this community **1 Day**

3. (a) PRINT FULL NAME **Wendell 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 **Single**

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive **10** years

7. Birth date of deceased **Sept. 10 1944**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	2	10	2	hr. min.

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

10. Usual occupation **Infant**

11. Industry or business

12. Name **Vernie Wright**

13. Birthplace **Webster County Missouri**
(City, town, or county) (State or foreign country)

14. Maiden name **Amy Johns**

15. Birthplace **Douglas County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Vernie Wright**

(b) Address **Fordland, Mo.**

17. (a) **Removal** (b) Date thereof **7/14/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Fordland, Mo.**

18. (a) Signature of funeral director **Kelly, Ferrell Bergman**

(b) Address **Fordland, Mo.**

19. (a) **7-12-47** (b) **W E Hurdley MD**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Webster**

(c) City or town **Fordland**
(If outside city or town limits, write "RURAL")

(d) Street No. **0**
(If rural, give location)

(e) Citizen of foreign country? **0**
(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **12** year **1947** hour **3** minute **25 P.M.**

21. I hereby certify that I attended the deceased from **7-12-47** 19 to **7-12-47** 19
that I last saw h. **live** on **7-12-47** 19
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute hepatitis**
Cause undetermined

Due to

Due to

Other conditions **105-B**
(Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **Same**

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?

23. Signature **E. J. Schingit** (M. D.)
Address **420 Mud Lake Bldg Springfield** Date signed **7-12-47**

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

MOTHER FATHER

39
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.....

Licensed Embalmer No.....

P. O. Address.....

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.