

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

**FILED AUG 5 1947**

Registration District No. \_\_\_\_\_

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Children's Mercy Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 wks. x 3 days  
(Specify whether  
In this community 3 weeks 3 days  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper **49**  
(c) City or town Joplin **2**  
(If outside city or town limits, write "RURAL") **5**  
(d) Street No. 215 St. Charles  
(If rural, give location) **1**  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Patsy Lorraine Wright

3. (b) If veteran, name war no 3. (c) Social Security No. none

4. Sex F / 5. Color or race W.  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 17, 1947  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
3 29 hr. min.

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

10. Usual occupation infant

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Willard Clinton Wright

13. Birthplace Saxton Pennsylvania  
(City, town, or county) (State or foreign country)

14. Maiden name Lois Maxine Demery

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

16. (a) Informant Mother - Mrs. E. Wright  
(b) Address 215 St. Charles, Joplin, Mo.

17. (a) Removed (b) Date thereof 7-16-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Joplin, Mo.

18. (a) Signature of funeral director Mrs. E. L. Foster  
(b) Address Kansas City, Mo.

19. (a) 7-16-47 (b) Sheraldine Holmer  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 16  
year 1947 hour 12 minute 02 A.M.

21. I hereby certify that I attended the deceased from  
Pathologist 1947 to 7-16, 1947  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to Cerebral hypoxia of left ventricle  
due to bilateral atherosclerosis  
Due to Mediastinal emphysema

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 105

Major findings: Trochocysty  
Of operations \_\_\_\_\_  
Of autopsy found

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 [Signature] (M. D. or other) MD  
Address [Signature] Date signed 16/9/47

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

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

56 e<sup>2</sup>  
161a  
113  
105:1

*Joseph W. ...*

**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..... *Dean Owens* .....

Licensed Embalmer No. *4280* .....

P. O. Address *918 Brookline* .....

*K.C., 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.**