

FILED JAN 26 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

124

Registration District No. 32

Primary Registration District No. 404-2

Registrar's No. 3

1. PLACE OF DEATH:

(a) County BOLLINGER
(b) City or town LUTESVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MOUSER NURSING HOME #4
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 week
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME ROBERT CARROLL WRIGHT

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 21

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

7. Birth date of deceased March 5 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 9 26 hr. min.

9. Birthplace Cape County
(City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business _____

12. Name James Thomas Wright

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

14. Maiden name Angeline Brown

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

16. (a) Informant _____

(b) Address _____

17. (a) Burial (b) Date thereof Jan 3/1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Cemetery

18. (a) Signature of funeral director Wm S Marshall

(b) Address Greenfield, Mo

19. (a) Jan - 14-48 (b) William H. Marshall
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wayne
(c) City or town Silva
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 7
year 1948 hour _____ minute _____

21. I hereby certify that I attended the deceased from Dec 27 1947 to Jan 7 1948
that I last saw him alive on Jan 7 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration _____

Due to Cerebral Hemorrhage

Due to Senility

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 83A

Of autopsy _____

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? _____

(Specify type of place) (c) Means of injury _____

While at work? _____

23. Signature W. S. Marshall (M: Doctor)
Address Greenfield, Mo Date 1/11/48

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District Health Officer No. 4
District File Number 148-90
Date Filed 1-19-48

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 William Coder

Licensed Embalmer No. 3723

P. O. Address Cedmont, 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.