

Registration District No. **372**

Primary Registration District No. **6286**

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Wright Rural  
(b) City or town nth trave Wood Rly  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 5 Days (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Luna **39**  
(c) City or town Springfield Mo **2**  
(If outside city or town limits, write "RURAL") **6**  
(d) Street No. 2038 N. Douglas **1**  
(If rural, give location)  
(e) Citizen of foreign country? no (X  No)

3. (a) PRINT FULL NAME

George Franklin Wright

3. (b) If veteran, name war no

3. (c) Social Security No. 702-07-5203

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Agnes Wright

6. (c) Age of husband or wife if alive 48 years

7. Birth date of deceased October 11 1894  
(Month) (Day) (Year)

8. AGE: Years 63 Months 8 Days 4 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Olatcha - Kansas  
(City, town, or county) (State or foreign country)

10. Usual occupation Rail Road Shop (Retired)

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

12. Name Wm Franklin Wright

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

14. Maiden name Martha Ann Dawson

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

16. (a) Informant Mrs Agnes Wright

(b) Address 2038 N Douglas

17. (a) Burial Springfield Mo. 6-19-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director W. K. King & Co

(b) Address Springfield Mo

19. (a) 6-16-48 (Date received local registrar)  
(b) A. B. Ames (Registrar's signature) **347**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 15  
year 1948 hour 7:35 minute \_\_\_\_\_ p.m.

21. I hereby certify that I attended the deceased from June 14 - 1948 to June 15 - 1948  
that I last saw him alive on June 15 - 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings: Of operations 130

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause of 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) While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature P. M. Shively (M. D. or other) **0**

Address Mrs. Home No. Date signed 6/16/48

SEP 21 1948

RECEIVED

District Health Officer No. 6,

District File Number 748-752

Date Filed JUL 12 1948

JUL 27 1948

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 \_\_\_\_\_

working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed *J. B. Kelen*

Licensed Embalmer No. 85358

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.