

FILED SEP 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29285

BIRTH NO. _____		REG. DIST. NO. <u>38</u>		PRIMARY REG. DIST. NO. <u>3006</u>		Registrar's No. <u>232</u>	
1. PLACE OF DEATH a. COUNTY <u>Boone</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. LENGTH OF STAY (in this place) <u>1 1/2 unknown</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		10 <u>10</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Sanford Convalescent Home</u>				d. STREET ADDRESS (If rural, give location) <u>301 N. 5th St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CENIE</u>		b. (Middle) <u>—</u>		c. (Last) <u>WRIGHT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>9-3-1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>		8. DATE OF BIRTH <u>1863</u>	
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 4 HRS. Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>unknown</u>		13b. MOTHER'S MAIDEN NAME <u>unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Aron Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Clinton Wright</u>		ADDRESS <u>Columbia, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage, spontaneous</u> ANTECEDENT CAUSES <u>Non-traumatic</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>—</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3:31X</u>	
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>—</u>		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>9-2</u> 19 <u>49</u> , to <u>9-3</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>9-2</u> , 19 <u>49</u> , and that death occurred at <u>4:15</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Roland P. Fadenroy MD</u>				23b. ADDRESS <u>16 S. 10th St.</u>		23c. DATE SIGNED <u>9-7-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>9-5-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Celestial</u>		24d. LOCATION (City, town, or county) (State) <u>Boone Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>Sept 7, 1949</u>		REGISTRAR'S SIGNATURE <u>Mrs R E Palmer</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Street Parkes Columbia, Mo.</u>			

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

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2
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RECEIVED SEP 13 1945
District Health Officer No. 9,
District File Number.....

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, ~~on~~ by

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *Stuart P. Parker*

Licensed Embalmer No. *2900*

P. O. Address *Columbia, 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.