

FILED JUL 31 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24064

BIRTH NO. _____		REG. DIST. NO. <u>209</u>		PRIMARY REG. DIST. NO. <u>3043</u>		Registrar's No. <u>256</u>		
1. PLACE OF DEATH a. COUNTY <u>Marion county</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Missouri</u> COUNTY <u>Shelby</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Hannibal, Mo.</u>		c. LENGTH OF STAY (in this place) <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Shelbina, Mo.</u>		OR TOWN <u>1071</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospt.</u>				d. STREET ADDRESS (If rural, give location) <u>X</u>				
3. NAME OF DECEASED (Type or Print) <u>Bertha O'Dell Wright</u>			a. (First)			b. (Middle)		
c. (Last)			4. DATE OF DEATH <u>7-17-1950</u>			a. (Month) (Day) (Year)		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-8-1882</u>		9. AGE (In years last birthday) <u>68</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>9</u>	IF UNDER 2 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>William O'Dell</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Broyles</u>		14. NAME OF HUSBAND OR WIFE <u>Robert W. Wright</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>X</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>R. W. Wright, Shelbina, 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary Embolism</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Surgery</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>Obstruction of sigmoid</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5705</u>	
19a. DATE OF OPERATION <u>7-7-50</u>		19b. MAJOR FINDINGS OF OPERATION <u>Obstruction of sigmoid (thrombosis)</u>						
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>50</u> , to <u>July 17</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>50</u> , and that death occurred at <u>3:40 A.M.</u> from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>1001 Edwy, Hannibal, Mo.</u>		23c. DATE SIGNED <u>7-18-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>7-19-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Shelbina, Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Shelbina, Mo.</u>			
DATE REC'D BY LOCAL REG. <u>7-24-50</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Million-Barkelaw, Shelbina, Mo.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED JUL 28 1950
MARION CO. HEALTH DEPT.
DATE FILED 7-29-50.

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

W. H. Hawkins

Licensed Embalmer No. 3498

P. O. Address Helena 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.