

FILED SEP 26 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

29365

State File No.

BIRTH NO. _____ REG. DIST. NO. 16 PRIMARY REG. DIST. NO. 4030 Registrar's No. 14

0060

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

1. PLACE OF DEATH a. COUNTY Barton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Barton	
b. CITY (If outside corporate limits, write RURAL and give town) Golden City	c. LENGTH OF STAY (in this place) 65 yrs.	c. CITY (If outside corporate limits, write RURAL and give township) Golden City 0060	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) Scyndrella b. (Middle) Ellen c. (Last) Wright			4. DATE OF DEATH (Month) (Day) (Year) Sept. 10 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 24, 1876	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months 5 Days 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Boone Co., Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Spencer Lee Staats		13b. MOTHER'S MAIDEN NAME Jane Johnson		14. NAME OF HUSBAND OR WIFE George W. Wright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT'S SIGNATURE OR NAME ADDRESS George W. Wright Golden City, Mo.	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 19 hr.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis		
	DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			33 IX
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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)
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 Oct 6, 1947 to Sept 10, 1950, that I last saw the deceased alive on Sept 9, 1950, and that death occurred at Golden City, Mo. from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Raymond A. Carlson M.D.		23b. ADDRESS Golden City, Mo.		23c. DATE SIGNED 9-12-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 14, 1950	24c. NAME OF CEMETERY OR CREMATORY I.O.O.F.	24d. LOCATION (City, town, or county) (State) Golden City, Mo.		

DATE REC'D BY LOCAL REG. Sept 12-1950	REGISTRAR'S SIGNATURE Nazel H. Pugh	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Phillips Funeral Home Golden City, Mo.
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DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED SEP 19 1950

Dist. File 950-1961

Date Filed 9-23-50

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 J. H. Brough

Licensed Embalmer No. 3278

P. O. Address Golden City, 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.