

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37953

FILED DEC 2 1950

BIRTH NO. _____		REG. DIST. NO. <u>2</u>	PRIMARY REG. DIST. NO. <u>5742</u>	Registrar's No. <u>87</u>
1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-E. Valley Twp.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural- E. Valley Twp.</u>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>8 miles N.W. Callao</u>		d. STREET ADDRESS (If rural, give location) <u>8 Miles N.W. of Callao</u>		
3. NAME OF DECEASED a. (First) <u>John</u> b. (Middle) <u>Biddle</u> c. (Last) <u>Wright</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 10, 1950</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 7, 1884</u>	9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Blandamon Wright</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bealmear</u>	14. NAME OF HUSBAND OR WIFE <u>Myrtle Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>XXXX</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Myrtle Wright, Callao, 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* <u>Idea of Carcinoma of the Biliary Tract.</u> MORIBUND CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Unknown</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>153X</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <u>8/8/50</u> 19 <u>50</u> , to <u>11/10/1950</u> , that I last saw the deceased alive on <u>11/8/1950</u> , and that death occurred at <u>2 noon</u> from the causes and on the date stated above.				
23a. SIGNATURE <u>J. L. Durden, D.O.</u> (Degree or title)		23b. ADDRESS <u>Macon, Mo.</u>		23c. DATE SIGNED <u>11/13/50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Nov. 12, 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>New Chariton Cemetery N.W. of Callao, Mo.</u>		24d. LOCATION (City, town, or county) (State) <u>New Cambria Mo.</u>
DATE REC'D BY LOCAL REG. <u>11/14/50</u>	REGISTRAR'S SIGNATURE <u>Josephine King</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>King & Hill New Cambria Mo.</u>		

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

RECEIVED 11-28-50
MACON COUNTY HEALTH DEPARTMENT
County File No. 11.50.214
Date Filed 11.30.50

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Date Received: NOV 22 1950
DISTRICT HEALTH OFFICE #2
District File Number
Date Filed:

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 H. J. Gilleland
Licensed Embalmer No. 4019

P. O. Address New Cambria 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.