

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9328**

FILED MAR 17 1953

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BIRTH NO. _____ REG. DIST. NO. **109** PRIMARY REG. DIST. NO. **4180** Registrar's No. **5**

1. PLACE OF DEATH a. COUNTY Dunklin		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY Dunklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gambell		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gambell	
c. LENGTH OF STAY (in this place) Yrs.		d. STREET ADDRESS (If rural, give location) 615 S. Main	
d. FULL NAME OF HOSPITAL OR INSTITUTION			

3. NAME OF DECEASED (Type or Print) Dell	a. (First)	b. (Middle) Wright	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Feb. 4, 1953
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 1, 1882	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours	Min.
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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 (City and State or Foreign Country) Mo.	12. CITIZEN OF WHAT COUNTRY U. S.
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13a. FATHER'S NAME Jessie Hampton	13b. MOTHER'S MAIDEN NAME Marcelline Hanover	14. NAME OF HUSBAND OR WIFE Sam N. Wright
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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. none	17. INFORMANT'S SIGNATURE OR NAME Sam N. Wright ADDRESS Gambell, Mo.
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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		INTERVAL BETWEEN ONSET AND DEATH 10 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Empyema of Gall bladder		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Gall bladder disease		
DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 586x YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 1953**, to **Feb 4, 1953**, that I last saw the deceased alive on **Feb 3, 1953**, and that death occurred at **3 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Wm E Cochran (Degree or title)	23b. ADDRESS PO Box 401 Gambell Mo.	23c. DATE SIGNED Feb 5, 1953
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24a. BURIAL, CREMATION, REMOVAL (Specify) Buried	24b. DATE Feb. 6, 1953	24c. NAME OF CEMETERY OR CREMATORY Standard W.M.	24d. LOCATION (City, town, or county) (State) Dunklin Mo.
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DATE REC'D BY LOCAL REG. 3/10/53	REGISTRAR'S SIGNATURE Mrs. Jewel Campbell	25. FUNERAL DIRECTOR'S SIGNATURE H. Irby ADDRESS Rector, Ark.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

350
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RECEIVED DUNKLIN COUNTY HEALTH

DEPARTMENT 3-16-53

COUNTY FILE NUMBER 253-23

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

Don W. McBride

Licensed Embalmer No. 776

P. O. Address Rector, Ark.

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.