

STANDARD CERTIFICATE OF DEATH

24048

State File No.

FILED AUG 5 - 1953

BIRTH NO. REG. DIST. NO. **43** PRIMARY REG. DIST. NO. **3007** Registrar's No. **315**

1. PLACE OF DEATH a. COUNTY Butler		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Shannon	
b. CITY OR TOWN poplar bluff		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Winona	
c. LENGTH OF STAY (If this place) 5 days		d. STREET ADDRESS (If rural, give location) 1010	
d. FULL NAME OF HOSPITAL OR INSTITUTION		e. STREET ADDRESS	

3. NAME OF DECEASED (Type or Print) Caroline		a. (First)	b. (Middle)	c. (Last) Wright	4. DATE OF DEATH (Month) (Day) (Year) July 21 1953		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH May 6, 1879	9. AGE (In years last birthday) 74	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellington Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Andy Chitwood		13b. MOTHER'S MAIDEN NAME Alta Davis		14. NAME OF HUSBAND OR WIFE John Wright	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME John Wright, Winona, Mo.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 7-19-53	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease		DUE TO (b) Arteriosclerosis			
		ANTECEDENT CAUSES		DUE TO (c)			
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201					

19a. DATE OF OPERATION 7-17-53		19b. MAJOR FINDINGS OF OPERATION Swelling of gall bladder, cholecystitis		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, etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 **7-17**, 19**53**, to **7-21**, 19**53**, that I last saw the deceased alive on **7-21**, 19**53**, and that death occurred at **1:20 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]		(Degree or title)		23b. ADDRESS [Address]		23c. DATE SIGNED 7/27/53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 7-23-53		24c. NAME OF CEMETERY OR CREMATORY Chitwood Cemetery		24d. LOCATION (City, town, or county) (State) Winona Mo.	
DATE REC'D BY LOCAL REG. 7/29/53		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Seaton Sewitt Van Buren Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

RECEIVED
AUG 3 1953

BUTLER CO. HEALTH CENTER

FILE No. _____

FILE No. _____
BUTLER CO. HEALTH CENTER

RECEIVED

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 Seaton Pewitt

Licensed Embalmer No. 2287

P. O. Address Van Buren 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.