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FILED OCT 13 1953

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 32494

BIRTH NO. _____ REG. DIST. NO. 747 PRIMARY REG. DIST. NO. 5830 Registrar's No. 18

1. PLACE OF DEATH
a. COUNTY New Madrid
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 2 Mile North Canalou, Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY New Madrid
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Morehouse, Mo 0720
d. STREET ADDRESS (If rural, give location) 0

3. NAME OF DECEASED (Type or Print)
a. (First) Albert
b. (Middle) D
c. (Last) Wright

4. DATE OF DEATH (Month) 9 (Day) 30 (Year) 1953

5. SEX M 0
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S 0
8. DATE OF BIRTH 11/13/90
9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months 10 Days 0 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY Cotton Picker
11. BIRTHPLACE (City and State or Foreign Country) Ky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Caleb Wright
13b. MOTHER'S MAIDEN NAME Ritta D. Bell
14. NAME OF HUSBAND OR WIFE X X

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. _____
17. INFORMANT'S SIGNATURE OR NAME Ezra Lee Wright Morehouse, Mo ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull — INTERVAL BETWEEN ORSET AND DEATH instantly

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
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 E802X 35
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) ✓
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1 Mi North Canalou, Mo.
21c. (CITY, TOWN, OR TOWNSHIP) Canalou (COUNTY) New Madrid 0720 (STATE) Mo.

21d. TIME OF INJURY (Month) 9 (Day) 30 (Year) 1953 (Hour) 11:30 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Hit by a Railroad engine

22. *I hereby certify that I attended the deceased from* 9-30, 1953, *to* 9-30, 1953, *that I last saw the deceased alive on* 9-30, 1953, *and that death occurred at* 11.30 A., *from the causes and on the date stated above.*

23a. SIGNATURE F. M. Sarno (Degree or title) M.D.
23b. ADDRESS Morehouse, Mo
23c. DATE SIGNED 10-2-53

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/1/53
24c. NAME OF CEMETERY OR CREMATORY City Cemetery
24d. LOCATION (City, town, or county) Sikeston, Mo (State)

DATE REC'D BY LOCAL REG. 10/8-53
REGISTRAR'S SIGNATURE Thomas M. Sheeter 220
25. FUNERAL DIRECTOR'S SIGNATURE Harry Jones Sikeston Mo ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

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 John Allutto

Licensed Embalmer No. 12941

P. O. Address Lakeston

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.