

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31205**

FILED OCT 13 1954

BIRTH NO. _____ REG. DIST. NO. **195** PRIMARY REG. DIST. NO. **5715** Registrar's No. **80**

0660

1. PLACE OF DEATH a. COUNTY McDonald		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY McDonald	
b. CITY OR TOWN JANE		c. CITY (If outside corporate limits, write RURAL and give township) JANE	
c. LENGTH OF STAY (In this place) 1 YR		d. STREET ADDRESS (If rural, give location) NONE	
d. FULL NAME OF HOSPITAL OR INSTITUTION NONE			

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) EMMA c. (Last) WRIGHT			4. DATE OF DEATH (Month) (Day) (Year) 7-17-54		
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	
8. DATE OF BIRTH 2-2-1868		9. AGE (In years less birthday) 86		10. IF UNDER 1 YEAR: Months 5 Days 15	
11. BIRTHPLACE (City and State or Foreign Country) Old Boston, Mo		12. CITIZEN OF WHAT COUNTRY? US			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE			

13a. FATHER'S NAME W. A. CAUTWELL		13b. MOTHER'S MAIDEN NAME SARAH MURRAY		14. NAME OF HUSBAND OR WIFE J. F. 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. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS W. A. WRIGHT, JANE 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility ANTECEDENT CAUSES As for conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Diabetes m. 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 ?
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 2600X		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) (m.)		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 **Jan 2, 1954**, to **July 17, 1954**, that I last saw the deceased alive on **July 17, 1954**, and that death occurred at **6 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Scott Russell		23b. ADDRESS Genevieve - mo		23c. DATE SIGNED 10/8/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 7-19-1954		24c. NAME OF CEMETERY OR CREMATORY Buckhins	
				24d. LOCATION (City, town, or county) (State) Buckhins Mo.	

DATE REC'D BY LOCAL REG. 10-8-54		REGISTRAR'S SIGNATURE Maxwell Humphrey		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS Maxwell Humphrey, Bureau of Health	
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(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 Mayne E. Humphrey
Licensed Embalmer No. 42,02

P. O. Address Parisville, 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.