

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

26442

BIRTH NO. _____		REG. DIST. NO. <u>99</u>		PRIMARY REG. DIST. NO. <u>5379</u>		Registrar's No. <u>44</u>		
1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) -a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>				
b. CITY (If outside corporate limits, write RURAL and give town) <u>Clarksdale</u>		c. LENGTH OF STAY (in this place) <u>life</u>		c. CITY OR TOWN <u>Clarksdale</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>0</u>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home, 3 Mi e. of town</u>				e. STREET ADDRESS (If rural, give location) <u>town</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u>		b. (Middle) <u>Mitchell</u>		c. (Last) <u>Wright</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>8 - 10 - 56</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>12-17-1876</u>		
9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 6 Hrs. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>Mo.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13a. FATHER'S NAME <u>John Wright</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Deppen</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Aubrey Wright Clarksdale 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* (a) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
		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 _____				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) <u>4201</u>				
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 <u>June 25, 1956</u> , to <u>Aug 10, 1956</u> that I last saw the deceased alive on <u>Aug 10, 1956</u> and that death occurred at <u>5:00 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>Dr. Gerald Taylor M.D.</u>				23b. ADDRESS <u>Maysville Mo</u>		23c. DATE SIGNED <u>8/12/56</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>8-12-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Clarksdale</u>		24d. LOCATION (City, town, or county) (State) <u>Clarksdale Mo</u>		
DATE REC'D BY LOCAL REG. <u>8-23-56</u>		REGISTRAR'S SIGNATURE <u>Russell Davidson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Brown</u>		ADDRESS <u>Maysville Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

820

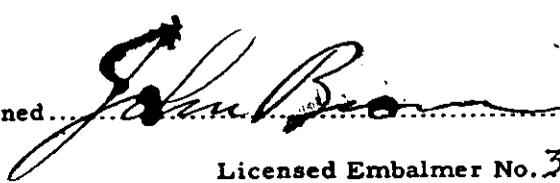
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STATEMENT BY LICENSED EMBALMER

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.....  
Signature of Student Embalmer

Signed.....  


Licensed Embalmer No. 3933.....

P. O. Address Maysville, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.