

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-036010
STATE FILE NUMBER

FILED NOV 10 1958

Registration District No. 118 Primary Registration District No. 5437 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <u>Gasconade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Gasconade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bourbois Twp.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Owensville</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Farm Home</u>		Length of stay in lb <u>60 yrs.</u>	d. STREET ADDRESS (If outside, give location) <u>Rural Route 3</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Franklin</u> Last <u>Wright</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>29</u> Year <u>1958</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 4, 1875</u>
9. AGE (In years last birthday) <u>85</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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>Farming</u>	11. BIRTHPLACE (City and state or country) <u>Jakes Prairie, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>William M. Wright</u>	
13b. MOTHER'S MAIDEN NAME <u>Virginia Licklider</u>		14. NAME OF HUSBAND OR WIFE <u>Cora Watson Wright</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>488-42-9241</u>	17. INFORMANT <u>Mrs. Cora Wright</u> Address <u>Owensville, Mo. Rt 3</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>CARDIAC ANOXIA</u>			<u>7 min</u>
DUE TO (c) <u>CORONARY EMBOLISM</u>			<u>4201</u> <u>7 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetic + Advanced Age</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>0</u> a.m. <u>0</u> p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>11-10-57</u> to <u>10-29-58</u> and last saw ^{her} <u>him</u> alive on <u>10-29-58</u> Death occurred at <u>3:15 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Wm Licklider</u> (Degree or title) <u>2</u>		22b. ADDRESS <u>Bland, Mo</u>	22c. DATE SIGNED <u>10/1/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>11-1-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Licklider Cemetery</u>	23d. LOCATION (City, town, or country) (State) <u>Jakes Prairie, Mo.</u>
24. FUNERAL DIRECTOR <u>Michael H Winter</u> ADDRESS <u>OWENSVILLE</u>		25. DATE RECD. BY LOCAL REG. <u>November 1, 1958</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Merwin Jappney</u>

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300
1-57

1

93

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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 Me, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Myself H H Winter

Licensed Embalmer No. 3838

P. O. Address. OWENSVILLE

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.