

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028815

FILED VS AUG 18 1959 33

Registration District No. 33 Primary Registration District No. 3022 Registrar's No. 96

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY Harrison				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Harrison					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Bethany		Length of stay in 1b 4 hours		c. CITY OR TOWN Mt. Moriah		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Noll Memorial Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Albert Earle Wright				4. DATE OF DEATH Month August Day 6 Year 1959					
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 6-26-25	9. AGE (last birthday) 34	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Wright Feed & Grain		11. BIRTHPLACE (City and state or country) Mt. Moriah, Mo.		12. CITIZEN OF WHAT COUNTRY U. S. A.		
13a. FATHER'S NAME Walter N. Wright			13b. MOTHER'S MAIDEN NAME Vava Opal Fomes			14. NAME OF HUSBAND OR WIFE Mary Kathryn Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W. W. II 8-17-43			16. SOCIAL SECURITY NO. 492-20-7025		17. INFORMANT Walter N. Wright.			Address Mt. Moriah, Mo.	
18. CAUSE OF DEATH (Enter on foregoing page 21, link for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EPI DURAL HEMORRHAGE							INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) BASILAR SKULL FRACTURE.							4 1/2 hrs		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PROB. FRACTURE OF UPPER THORACIC SPINE.						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) FELL FROM GRAIN BIN WHILE WELDING						
20c. TIME OF INJURY Hour 12:45 p.m. Month, Day, Year 8-6-59		20d. INJURY OCCURRED WHILE AT WORK <input checked="" 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.) GRAIN ELEVATOR			20f. CITY, TOWN, OR LOCATION MT. MORIAH						
20g. COUNTY HARRISON			20h. STATE MO.						
21. I attended the deceased from 8-6-59 at 1:30 pm. to 8-6-59-5:30 pm and last saw him alive on 8-6-59 Death occurred at 5:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE Albert D. White (Dr. or title)				22b. ADDRESS Bethany, Missouri.				22c. DATE SIGNED 8-8-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-8-59	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah, Cemetery			23d. LOCATION (City, town, or county) (State) Mt. Moriah, Mo.			
24. FUNERAL DIRECTOR [Signature] ADDRESS Cainsville, Mo.			25. DATE RECD. BY LOCAL REG. 8-8-59		26. REGISTRAR'S SIGNATURE Gella Mayey.				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

698 6 T 5M7

JUN 6 1962

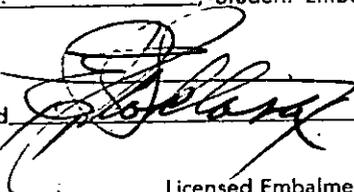
JUN 22 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by of *HH* Eddie J. Stoklasa Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 3602

P. O. Address Cainsville, 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.