

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-010637

FILED VS MAR 21 1960

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 320

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Greene			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield			Length of stay in 1b		c. CITY OR TOWN Springfield		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Johns Hospital			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 822 E. Lynn		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HARRY Middle A. Last WRIGHT				4. DATE OF DEATH Month March Day 14 Year 1960			
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 April 1, 1877	
9. AGE (last birthday) 82		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. RR. Conductor			10b. KIND OF BUSINESS OR INDUSTRY Frisco RR		11. BIRTHPLACE (City and state or country) Missouri		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME C.P. Wright			13b. MOTHER'S MAIDEN NAME Agnes Lee			14. NAME OF HUSBAND OR WIFE Maude 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.		17. INFORMANT Maude F. Wright Address Springfield, Mo.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis (or hemorrhage) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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							INTERVAL BETWEEN ONSET AND DEATH Feet hrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input 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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <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 1957 to 3-14-60 and last saw him alive on 3-14-60 Death occurred at 10:45 AM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE [Signature] (Degree or title)			22b. ADDRESS Springfield, Mo.			22c. DATE SIGNED 3-16-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-17-60		23c. NAME OF CEMETERY OR CREMATORY Maple Park Cemetery		23d. LOCATION (City, town, or county) (State) Springfield, Missouri	
24. FUNERAL DIRECTOR Klingner Mortuary ADDRESS Springfield, Mo.			25. DATE RECD. BY LOCAL REG. 3-17-60		26. REGISTRAR'S SIGNATURE [Signature]		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

MAR 22 1966

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max Phoad
40

Licensed Embalmer No. _____

P. O. Address Spring

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.