

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-045433**

FILED VS JAN 10 1961

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Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **3**

STATE FILE NUMBER

|   |   |   |  |   |   |  |  |
|---|---|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Clark County</b>  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Mo.</b> b. COUNTY <b>Clark</b> |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>Luray, Mo.</b>  |   | Length of stay in 1b  |  | c. CITY OR TOWN <b>Luray, Mo.</b>   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                    |   | d. STREET ADDRESS (If outside, give location)                   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>LIZZIE EDITH WRIGHT</b>  |   |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>12/26/60</b>   |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10/31/1893</b>   | 9. AGE (last birthday)<br><b>67</b>                             | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HR   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and state or country)<br><b>Luray, Mo.</b> |  | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>                                  |
| 13a. FATHER'S NAME<br><b>Charles Hoop</b>   |   |   | 13b. MOTHER'S MAIDEN NAME<br><b>Sarah Poe, Hoop</b>  |   |   | 14. NAME OF HUSBAND OR WIFE<br><b>Conda Wright</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>486-38-6842-B</b>   |  | 17. INFORMANT Address<br><b>Conda Wright, Luray, Mo.</b>  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:  |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| IMMEDIATE CAUSE (a) <b>Medullary failure</b>  |   |   |  |   |   |  | <b>minutes</b>   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |   |   |  |   |   |  |  |
| DUE TO (b) <b>Cerebral encyphalomalacia and hemorrhage months</b>   |   |   |  |   |   |  |  |
| DUE TO (c) <b>Arteriosclerosis</b>  |   |   |  |   |   |  | <b>Unknown</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>Diabetes mellitus</b>   |   |   |  |   |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input 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<br>Hour a.m. p.m.   | Month, Day, Year  |   |  |   |   |  |  |
| 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 <b>2-8-60</b> to <b>12-26-60</b> and last saw him alive on <b>12-26-60</b><br>Death occurred at <b>9:30 p</b> m on the date stated above, and to the best of my knowledge, from the causes stated. |   |   |  |   |   |  |  |
| 22a. SIGNATURE (Degree or title)<br><b>R. L. Willis, Jr.</b>  |   |   |  | 22b. ADDRESS<br><b>Kahoka, Mo.</b>  |   | 22c. DATE SIGNED<br><b>1-3-61</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE<br><b>12/29/60</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ashton Cemetery</b>  |  | 23d. LOCATION (City, town, or county) (State)<br><b>Ashton, Mo.</b>   |   |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Delbert Shoffer, Kahoka, Mo.</b>   |   |   | 25. DATE RECD. BY LOCAL REG.<br><b>1-7-61</b>  |   | 26. REGISTRAR'S SIGNATURE<br><b>J. R. Bridges</b>               |  |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William J. Rafter

Licensed Embalmer No. 5063

P. O. Address Kakaka

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to  
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.