

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

**-61-012285**

STATE FILE NUMBER

AMENDED

DATE ENTERED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDANT OF

Registration District No. 391 Primary Registration District No. 4504 Registrar's No. 7

FILED MAR 28 1961

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ADVANCE</u>		Length of stay in lb <u>1 1/2 yrs</u>	c. CITY OR TOWN <u>ADVANCE</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>PIKE TWP.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>PIKE TWP.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>L.</u> Last <u>WRIGHT</u>			4. DATE OF DEATH Month <u>MAR.</u> Day <u>15</u> Year <u>1961</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>10-29-82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TIMBER</u>	9. AGE (last birthday) <u>78</u> IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u> IF UNDER 24 HR Hours <u></u> Min. <u></u>
11. BIRTHPLACE (City and state or country) <u>Indian Springs, Ind.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Tom Wright</u>		13b. MOTHER'S MAIDEN NAME <u>TACEY JANE Coffey</u>	14. NAME OF HUSBAND OR WIFE <u>MARY K. 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. SECURITY NO.	17. INFORMANT <u>Miss Della Wright, SAN ANTONIO, TEX.</u> Address
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>Shock,</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause (last). DUE TO (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 Min</u> <u>1 Hour</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetic</u>			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 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>			
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 <u>Sept 58</u> , to <u>3-15-61</u> and last saw him alive on <u>3-8-61</u> Death occurred at <u>12:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>Advance Mo.</u>	22c. DATE SIGNED <u>3-16-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3-17-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORGAN MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ADVANCE, Mo.</u>
24. FUNERAL DIRECTOR <u>W. H. Morgan, Advance, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>3/20/61</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>	

**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 W. H. May

Licensed Embalmer No. 4640

P. O. Address Adonny

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.