

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-000050

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 34

STATE FILE NUMBER

FILED FEB 5 1962

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kirksville</u>		c. CITY OR TOWN <u>Kirksville</u>	
Length of stay in 1b <u>12 yrs</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>Kirksville Osteopathic</u>		d. STREET ADDRESS (If outside, give location) <u>409 S. Baltimore</u>	
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>VINA A. WRIGHT</u>			4. DATE OF DEATH Month Day Year <u>January 27 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <del>Married</del> <input checked="" type="checkbox"/> Never Married <input checked="" type="checkbox"/> <del>Widowed</del> <input type="checkbox"/> <del>Divorced</del> <input type="checkbox"/>	8. DATE OF BIRTH <u>2/10/75</u>
9. AGE (last birthday) <u>86</u>		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) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>Macon Co., Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>U S</u>		13a. FATHER'S NAME <u>Blandamon Wright</u>	
13b. MOTHER'S MAIDEN NAME <u>Elizabeth Belmar</u>		14. NAME OF HUSBAND OR WIFE	
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>NONE</u>	17. INFORMANT <u>Curtis Wright, Kirksville, Mo.</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>Pneumonia</u> DUE TO (b) <u>cystitis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Central arteriosclerosis</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 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 <u>Jan 19 1962</u> to <u>Jan 27, 1962</u> and last saw her alive on <u>Jan 27, 1962</u> Death occurred at <u>10:00 a</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. W. Ruff</u>		22b. ADDRESS <u>Kirksville Mo</u>	22c. DATE SIGNED <u>1-29-62</u>
23b. BURIAL OR CREMATION (Specify) <u>Burial</u>	23c. DATE <u>Jan. 29/62</u>	23d. NAME OF CEMETERY OR CREMATOR <u>New Chariton</u>	23e. LOCATION (City, town, or county) (State) <u>Macon Co. Mo.</u>
24. FUNERAL DIRECTOR <u>Foster Memorial Home, Kirksville, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>1-29-1962</u>	26. REGISTRAR'S SIGNATURE <u>Doris W. Ruff</u>

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION Curtis Wright

BY AFFIDAVIT OF

M. T. GUTENSOHN, D.O.

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 Novato Lister

Licensed Embalmer No. 4742

P. O. Address: Fukerelle, 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.