

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-039226

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 157 Primary Registration District No. 3028 Registrar's No. 200  
**FILED NOV 8 1962**

VS 300  
Rev. 4/59

1 0497

2 0060

3 2

4 0

5 2

6

7 1

8 0

9 422.1

10

11

12 90-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>JASPER</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>BARTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>CARTHAGE</b>		Length of stay in lb <b>3 1/2 yrs.</b>	c. CITY OR TOWN <b>GOLDEN CITY</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>720 CEDAR ST</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>NONE</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>WASHINGTON</b> Last <b>WRIGHT</b>			4. DATE OF DEATH Month <b>OCT.</b> Day <b>31</b> Year <b>1962</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT-28-1865</b>
9. AGE (last birthday) <b>97</b>		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	11. BIRTHPLACE (City and state or country) <b>JEFFERSON Co. IOWA</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		13a. FATHER'S NAME <b>THOMAS B. WRIGHT</b>	
13b. MOTHER'S MAIDEN NAME <b>SARAH E. PANGER</b>		14. NAME OF HUSBAND OR WIFE <b>SCYNDRELLA E. WRIGHT</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT Address <b>MRS. PAUL CORDER</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Chronic</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerosis-Myocardial degeneration</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) <b>Senility</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 MO</b>
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.)		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	
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 checked="" 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>Feb 1957</b> to <b>Oct 31, 1962</b> and last saw him alive on <b>Oct 12, 1962</b> Death occurred at <b>9:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>George H. Wood MD</b>		22b. ADDRESS <b>Carthage Mo</b>	22c. DATE SIGNED <b>Nov 1, 62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>11-3-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S.O.O.F. Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>GOLDEN CITY MISSOURI</b>
24. FUNERAL DIRECTOR ADDRESS <b>PHILLIPS FUNERAL HOME GOLDEN CITY</b>		25. DATE RECD. BY LOCAL REG. <b>11-2-62</b>	26. REGISTRAR'S SIGNATURE <b>Thy Denton</b>

USE BLACK INK OR TYPEWRITER RIBBON

**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 H. Lucille Bugh

Licensed Embalmer No. 4957

P. O. Address Golden City, 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.