

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

168-023753

STATE FILE NUMBER

Registration District No. 88 Primary Registration District No. 5329 Registrar's No. \_\_\_\_\_

FILED JUL 11 1963

DO NOT WRITE ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 0280

2 0280

3

4 0

5 1

6

7 0

8 2

9 4201

10

11

12 90-0

13 3-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Crawford</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Crawford</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Oak Hill Twp.</u>		Length of stay in 1b <u>62 yrs.</u>		c. CITY OR TOWN <u>Owensville</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Farm Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rural Route 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Arthur</u> Last <u>Wright</u>			4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1963</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>10-29-1883</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>		11. BIRTHPLACE (City and state or country) <u>Jakes Prairie, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>David Wright</u>		13b. MOTHER'S MAIDEN NAME <u>Eliza Wallace</u>	
14. NAME OF HUSBAND OR WIFE <u>Hattie Zinn Wright</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>no</u> <u>none</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Walter Wright - Owensville, Mo. Rt 3</u>		18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO (b) <u>Atherosclerosis</u> DUE TO (c) <u>Chronic Bronchitis &amp; Asthma - Bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u> <u>2 yrs</u>	
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	
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>1961</u> to <u>7-4-63</u> and last saw him alive on <u>7-2-63</u> Death occurred at <u>1 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Russell L. Jones, M.D.</u> (Degree or title)		22b. ADDRESS <u>Owensville, Mo.</u>		22c. DATE SIGNED <u>7-5-63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>7-7-1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Licklider Cemetery</u>	
23d. LOCATION (City, town, or county) <u>south of Owensville, Mo.</u>		23e. DATE RECD. BY LOCAL REG. <u>July 5-1963</u>		23f. REGISTRAR'S SIGNATURE <u>Mrs. Hazel Lichius</u>	
24. FUNERAL DIRECTOR <u>Gottenstroeter Funeral Home</u> <u>Owensville, Mo.</u>			25. (Licensed Embalmer) Statement on Reverse Side		

USE BLACK INK OR TYPEWRITER RIBBON

JUL 23 1961

**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 Melford R R Winter

Licensed Embalmer No. 3838

P. O. Address OWENSVILLE

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.