

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-043437

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 119 Primary Registration District No. 5493 Registrar's No. 51

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED DEC 11 1963

|                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                                      |                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Gasconade</u>                                                                                                                                                                                           |                                                                                                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Mo</u> b. COUNTY <u>Montgomery</u>                              |                                    |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><u>Rock</u>                                                                                                                                                                  |                                                                                                           | c. CITY OR TOWN <u>New Florence, Mo</u>                                                                                                                              |                                    |
| c. FULL NAME OF (If NOT in hospital, give location)<br><u>Frene Valley Nursing Home</u>                                                                                                                                                   |                                                                                                           | d. STREET ADDRESS (If outside, give location)<br><u></u>                                                                                                             |                                    |
| 3. NAME OF DECEASED<br>(Type or print) <u>John W Wright</u>                                                                                                                                                                               |                                                                                                           | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>4</u> Year <u>1963</u>                                                                                                    |                                    |
| 5. SEX <u>M</u>                                                                                                                                                                                                                           | 6. COLOR OR RACE <u>White</u>                                                                             | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH <u>11-14-1870</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u>                                                                                                                             |                                                                                                           | 10b. KIND OF BUSINESS OR INDUSTRY <u></u>                                                                                                                            |                                    |
| 13a. FATHER'S NAME <u>Thomas H Wright</u>                                                                                                                                                                                                 |                                                                                                           | 13b. MOTHER'S MAIDEN NAME <u>Dora Cox</u>                                                                                                                            |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or (unknown)) (If yes, give war or dates of service)<br><u>No</u>                                                                                                                |                                                                                                           | 16. SOCIAL SECURITY NO. <u>None</u>                                                                                                                                  |                                    |
| 17. INFORMANT <u>James Wright New Florence, Mo</u>                                                                                                                                                                                        |                                                                                                           | 14. NAME OF HUSBAND OR WIFE <u>Annie Wright</u>                                                                                                                      |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic pyelonephritis</u>                                                                             |                                                                                                           | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 yr</u>                                                                                                                      |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Carcinoma rt. eye</u>                                                                             |                                                                                                           | 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 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<br>Hour <u></u> a.m. <u></u> p.m. <u></u><br>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 <u></u> COUNTY <u></u> STATE <u></u>                                                                                                    |                                    |
| 21. I attended the deceased from <u>10-29-68</u> to <u>12-4-63</u> and last saw her/him alive on <u>12-2-63</u><br>Death occurred at <u>10:40 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. |                                                                                                           |                                                                                                                                                                      |                                    |
| 22a. SIGNATURE (Degree or title)<br><u>Carol T. Shaw, M.D.</u>                                                                                                                                                                            |                                                                                                           | 22b. ADDRESS <u>Hermann, Mo.</u>                                                                                                                                     |                                    |
| 22c. DATE SIGNED <u>12-6-63</u>                                                                                                                                                                                                           |                                                                                                           | 22d. DATE SIGNED <u>12-6-63</u>                                                                                                                                      |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>                                                                                                                                                                                | 23b. DATE <u>12-6-1963</u>                                                                                | 23c. NAME OF CEMETERY OR CREMATORY <u>Hugo Cemetery</u>                                                                                                              |                                    |
| 23d. LOCATION (City, town, or county) <u>New Florence, Mo</u>                                                                                                                                                                             |                                                                                                           | (State) <u></u>                                                                                                                                                      |                                    |
| 24. FUNERAL DIRECTOR <u>D B Baker New Florence, Mo</u>                                                                                                                                                                                    |                                                                                                           | 25. DATE RECD. BY LOCAL REG. <u>12-5-63</u>                                                                                                                          |                                    |
| 26. REGISTRAR'S SIGNATURE <u>Delma Uffelman</u>                                                                                                                                                                                           |                                                                                                           | 26. REGISTRAR'S SIGNATURE <u></u>                                                                                                                                    |                                    |

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

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 by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Leon Toebltman

Licensed Embalmer No. 5202

P. O. Address Hermann, 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.