

FILED MAR 26 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8264

State File No.

BIRTH NO.		REG. DIST. NO. <u>141</u>		PRIMARY REG. DIST. NO. <u>3025</u>		Registrar's No. <u>26</u>			
1. PLACE OF DEATH a. COUNTY <u>Howe 11</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY <u>TEXAS</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEST PLAINS</u>		c. LENGTH OF STAY (In this place) <u>1 day</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CASS TWP.</u> <u>1070</u>					
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>CHRISTA HOGAN HOSP.</u>				d. STREET ADDRESS (If rural, give location) <u>/</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u>		b. (Middle) <u>DANIEL</u>		c. (Last) <u>WRIGHT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAR. 7 1951</u>			
5. SEX <u>M</u> <u>O</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>DEC. 12, 1866</u> <u>8H</u>			
9. AGE (In years last birthday) <u>84</u>		IF UNDER 1 YEAR Months Days		IF UNDER 1 YEAR Hours Mins.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>FLINT, MICH. 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>JAMES WRIGHT</u>		13b. MOTHER'S MAIDEN NAME <u>ELIZABETH BURPEE</u>		14. NAME OF HUSBAND OR WIFE <u>MARY A. WRIGHT</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>MARY A. WRIGHT</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Heart Failure, Acute</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Pneumococcal Pneumonia</u> DUE TO (c) <u>Coronary & Cerebral Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>app. 8 hrs.</u> <u>492 X</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>3/3</u> 19 <u>51</u> , to <u>3/7</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>51</u> , and that death occurred at <u>8:45 P.</u> m., from the causes and on the date stated above.									
23a. SIGNATURE <u>W. B. Perkins, M.D.</u> (Degree or title)				23b. ADDRESS <u>Yellow Springs, Mo.</u>		23c. DATE SIGNED <u>3/9/51</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>March 10-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT GROVE</u>		24d. LOCATION (City, town, or county) (State) <u>TEXAS CO. MO.</u>			
DATE REC'D BY LOCAL REG. <u>3-14-51</u>		REGISTRAR'S SIGNATURE <u>Beatrice Cooke</u> <u>379</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Gaylord V. Elliott, Calver</u>					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MO.
District No. 5 - Springfield

RECEIVED MAR 19 1951

Dist. File 337-614

Date Filed 3-22-51

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
Student Embalmer

Signed

James L. Kestey

Licensed Embalmer No. 4718

P. O. Address

Calool, 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 this body is not embalmed, fact should be so stated above.