

S. No. 2
M-5-43
5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26464

State File No. _____

FILED JUL 24 1947
Registration District No. _____

Primary Registration District No. 6128

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Eminence
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Poplar Bluff Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week
(Specify whether _____)

In this community 45 years
(years, months or days)

3. (a) PRINT FULL NAME Hattie V. Wright

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F / race W

5. Color or race W

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife John K Wright

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased July 10 1885
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
<u>61</u>	<u>11</u>	<u>8</u>	hr. _____ min.

9. Birthplace Americus Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER

12. Name John Ward

13. Birthplace Ohio
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Barton

15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant John Freeman

(b) Address Eminence, Mo.

17. (a) Burial (b) Date thereof 6-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Eminence Cemetery

18. (a) Signature of funeral director Duncan Funeral Home

(b) Address Mountain View, Mo

19. (a) 7-11-47 (b) Walter Powell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shannon

(c) City or town Eminence
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18
year 1947 hour 3 minute 30 a. m.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations 9/25/47

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Frank Hyde (M. D. or other) _____

Address Eminence Date signed 6-22-47

RECEIVED

STATE NO. 5,

District: 747404

Date Filed: 7-22-47

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Joe B. Duman

Licensed Embalmer No. 4325

P. O. Address Mtn View, 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.