

S. N. A.

FILED JUN 19 1942 - 779

Registration District No. _____

Primary Registration District No. 10020A

Registrar's No. 20

1. PLACE OF DEATH:

(a) County St. Francois
 (b) City or town Bonne Terre, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location) _____
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community all his life years, months or days

3. (a) PRINT FULL NAME: James W. Wright

3. (b) If veteran, name war _____
 3. (c) Social Security No. None

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Malinda Wright
 6. (c) Age of husband or wife if alive 71 years
 7. Birth date of deceased Dec 11 1862
 (Month) (Day) (Year)

8. AGE: Years 79 Months 8 Days 5 If less than one day _____ hr. _____ min.

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

10. Usual occupation retired night watchman

11. Industry or business _____

MOTHER FATHER
 12. Name John Wright
 13. Birthplace Bartonsville Kentucky (City, town, or county) (State or foreign country)
 14. Maiden name Shuemaker
 15. Birthplace French Village Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Ben H. Wright
 (b) Address Leadwood Mo.

17. (a) Burial (b) Date thereof 5 17 1942 (Month) (Day) (Year)
 (c) Place: burial or cremation French Village

18. (a) Signature of funeral director E. J. Bauer
 (b) Address Desloge Mo.

19. (a) 5-15-42 (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
 (c) City or town Bonne Terre Mo. 99
 (If outside city or town limits, write "RURAL") _____
 (d) Street No. _____ (If rural, give location) _____
 (e) Citizen of foreign country? _____ (Yes or No) _____
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 14 year 1942 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from Apr 15 1942 to May 14 1942
 that I last saw him alive on May 14 1942
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis unknown
 Due to unknown

Due to _____
 Other conditions (Include pregnancy within 3 months of death) _____
 1318

Major findings: _____
 Of operations _____
 Of autopsy _____

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 J. F. Evans (M. D. or other) _____
 Address Somerset Mo. Date signed 5-15-42

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

1194

RECEIVED

4

District Health Officer No. 9734
District File Number 615
Date filed 6-11-71

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 E. Z. Boyer
Licensed Embalmer No. 1671
P. O. Address Desloge, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18906

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St Francis
(b) City or town Bonne Terre
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community _____
years, months or days)

3. (a) PRINT FULL NAME James W. Wright

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (If less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

MOTHER { 12. Name _____
FATHER { 13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) 5-15-42 (b) Byrdie Bukhmaster
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County St Francis
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day _____ year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____ to _____ 19____

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death chronic nephritis

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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) (e) Means of injury _____

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

Address _____ Date signed _____

Duration

unk

1312

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

