MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32146

1. PLACE OF DEATH

County ..... Registration District No. 791

Township ..... Primary Registration District No. 1003

City St. Louis (No. City Hospital #2 St. ..... Ward)

File No. ..... Registered No. 9530

2. FULL NAME David Wright

(a) Residence. No. 4371 Cook St., 11 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Col.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: not known

6. DATE OF BIRTH (MONTH, DAY AND YEAR): abt. Mar. ? 1899

7. AGE: abt. 28 YEARS; MONTHS: 7; DAYS: ?; If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): La.

PARENTS

10. NAME OF FATHER: Wilton Wright

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): La.

12. MAIDEN NAME OF MOTHER: Ida Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): La.

14. INFORMANT: Anna F. Woodard
(Address) City Hospital #2

15. FILED OCT 25 1927, 19..... Mark Starkcoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Oct. 21, 1927

17. I HEREBY CERTIFY, That I attended deceased from 7/6/, 1927, to 10/21/, 1927 that I last saw him alive on 10/21/, 1927, and that death occurred, on the date stated above, at 11:10 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
23A
indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 31 (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? not known

0 DID AN OPERATION PRECEDE DEATH? no. DATE OF .....

WAS THERE AN AUTOPSY? no.

WHAT TEST CONFIRMED DIAGNOSIS? clinical & fab.

(Signed) R. L. Howell, M. D

, 19 (Address) City Hosp. #2

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: St Louis V.

DATE OF BURIAL: 10/24 1927

20. UNDERTAKER: W. Richter

ADDRESS: 3800 Rutgers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.