

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.

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

669
Do not use this space.

REC'D FEB 10 1939

1. PLACE OF DEATH

(a) County..... / Registration District No. **791**
 (b) Township..... / Primary Registration District No. **1003**
 (c) City **St. Louis** (d) Street No. **Homer G. Phillips Hospital** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Lottie Wright**

(a) Residence, No. **3416 Lucas Ave.** St. **21**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **James Wright**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug. 4, 1900**

7. AGE YEARS **38** MONTHS **5** DAYS **14** If LESS than 1 day,hrs. ormin.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Laundress**
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

FATHER 13. NAME **Jack Jones**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Jackson Tennessee**

MOTHER 15. MAIDEN NAME **Sadie Bounds**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mississippi**

17. INFORMANT (ADDRESS) **Sadie Kirkmon 3416 Lucas Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **Jan. 23, 1939**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Russell Undertaking Co. 2732 Pine Street**

20. FILED **JAN 22 1939** **J. B. Bredner** Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Jan. 19, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **April 16, 1936**, to **Dec. 1, 1939**
 I last saw her alive on **Dec. 1, 1939**. Death is said to have occurred on the date stated above, at **12 a. m.**
 The principal cause of death and related causes of importance were as follows:

Myocarditis, chronic Date of onset

Other contributory causes of importance:

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 (Specify).....
 (Signed) **Paul D. Remus** M. D.
 (Address) **820 N. Grand Blvd**

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,

Joel Russell

or by

Registered Apprentice No., working under my personal supervision.

Signed

Joel Russell

Licensed Embalmer No.

2115-

P. O. Address

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, above space should be left blank.