

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

13135
Do not use this space.

REC'D MAY 10 1939

1. PLACE OF DEATH

(a) County..... Registration District No. **791**
 (b) Township..... Primary Registration District No. **1008**
 (c) City **St. Louis** (d) Street No. **Central 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 **56** yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME **Josephine Wright**

(a) Residence, No. **1810 South Jefferson** St. **23**
 (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 **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Wife of William H.**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Feb. 15, 1879**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 1 28

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
 9. Industry or business in which work was done, as saw mill, bank, etc. **At Home**
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation **13**

12. BIRTHPLACE (CITY OR TOWN) **St. Louis**
 (STATE OR COUNTRY) **Missouri**

FATHER 13. NAME **Unknown**

14. BIRTHPLACE (CITY OR TOWN) **Unknown**
 (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME **Unknown**

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

17. INFORMANT **Dr. Wm. H. Wright**
 (ADDRESS) **1810 South Jefferson**

18. BURIAL, CREMATION, OR REMOVAL
 PLACE **Valhalla Cem** DATE **4/15/39**

19. FUNERAL DIRECTOR (NAME) **A. W. McLaughlin**
 (ADDRESS) **2301 Lafayette Ave.**

20. FILED **APR 14 1939** **J. F. Buechler**
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Apr. 13, 1939**

22. I HEREBY CERTIFY, That I attended deceased from **April 9, 1939** to **April 13, 1939**

I last saw her alive on **April 13, 1939** Death is said to have occurred on the date stated above, at **11:10 AM.**

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis, and chronic interstitial nephritis,
To my knowledge, April 9, 1939

Date of onset

Other contributory causes of importance:
General anasarca,
To my knowledge, April 9, 1939

Name of operation **Urinalysis** Date of **No**
 What test confirmed diagnosis? **Urinalysis** 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? **No**
 If so, specify **Occupation**
 (Signed) **Dr. Wm. H. Wright**, M. D.
 (Address) **320 Metropolitan Bldg.**

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.

I X 10005

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 L.R. Cooper

Licensed Embalmer No. 3633

P. O. Address 237 Lafayette

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.