

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo. 15 days**
(Specify whether _____)
In this community **20 years**
(years, months or days)

3. (a) PRINT FULL NAME **Louis Wright**
3. (b) If veteran, name war _____ **3. (c) Social Security** No. **493-01-4861**

4. Sex **male** **5. Color or race** **Negro** **6. (a) Single, widowed, married, divorced** **married**
6. (b) Name of husband or wife **Channery Wright** **6. (c) Age of husband or wife if alive** **54** years
7. Birth date of deceased **9** (Month) **4** (Day) **1871** (Year)

8. AGE: Years **53** Months **1** Days **15** If less than one day _____ hr. _____ min.

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

10. Usual occupation **laborer**

11. Industry or business _____

MOTHER FATHER

12. Name **unknown**
13. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **unknown**
15. Birthplace **unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **Channery Wesley**
(b) Address **2206 Carr**

17. (a) Burial **(b) Date thereof** **10/24/44**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Mary Wade**
(b) Address **4202 Finney Ave**

19. (a) OCT 21 1944 **(b) JFB**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis,** **2/17**
(If outside city or town limits, write "RURAL")
(d) Street No. **2206 a Carr**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **19,**
year **1944** hour **3** minute **05** P. M.

21. I hereby certify that I attended the deceased from **September**
4, 19 **44** to **October 19,** 19 **44;**
that I last saw h. **im** alive on **October 19,** 19 **44;**
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Hypernephroma of right kidney with metastasis
Duration **Unk.**

Due to _____
Due to **52a**
Other conditions _____
(Include pregnancy within 3 months of death)

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) (e) Means of injury _____

23. Signature **JFB** (M.D. or other) _____
Address **66017 Whittier** Date signed **10/20/44**

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, ~~and~~.....

Chester A. Marshall

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Chester A. Marshall

Licensed Embalmer No.....

4381

P. O. Address.....

4202 E. Finne

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.