

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **128**

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 1217
(If outside city or town limits, write "RURAL")
(d) Street No. 339 N. Taylor Ave. 9
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No) 0
If yes, name country _____

3. (a) PRINT FULL NAME Emily Ruth Wright
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 4
year 1946 hour 2 minute 30.0 M.

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Robert J. Wright 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased March 16, 1870 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

8. AGE: Years 75 Months 9 Days 23 If less than one day _____ hr. _____ min.

Immediate cause of death Alactosia of brain
long (bas) stroke of left arm
when she fell while sitting
down from the step to porch
in front of church - 2000
at 6600 Watson Rd on Dec
30 1945 (Specify time when death occurred)

9. Birthplace New Madrid Missouri (City, town, or county) (State or foreign country)
10. Usual occupation Deaphan Society Organizer

Other conditions: _____ (Include pregnancy within 3 months of death)
Major findings: _____
Of operations: _____
Of autopsy: _____

11. Industry or business _____
12. Name John Summers
13. Birthplace Franklin Missouri (City, town, or county) (State or foreign country)
14. Maiden name Cathy Summers
15. Birthplace Roanoke Virginia (City, town, or county) (State or foreign country)

PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant Mary Beth Norman
(b) Address 1326 Hawthorn Place
17. (a) Burial (b) Date thereof July 6, 1945 (Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Organ Missouri
18. (a) Signature of funeral director Chas. A. Hall
(b) Address 457 Washington Blvd
19. (a) Jan 5, 1946 (Date read by local registrar) J. W. Bedeck (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accidental
(b) Date of occurrence Dec 30, 1945
(c) Where did injury occur? at home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
at home (Specify type of place) (e) Means of injury by fall
23. Signature John E. Summers (M. D. or other) 11/14/46
Address Key St Date signed 11/14/46

(Licensed Embalmer's Statement on Reverse Side)

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

3303

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 *John Ketter*
.....
Licensed Embalmer No. *2680*

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, fact should be so stated above.