

Registration District No. **318**

Primary Registration District No. **1003**

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: St. Luke's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3-weeks  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Kathryn A. Wright

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced M.  
(b) Name of husband or wife Clarence Wright 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased Sept. 25th., 1890  
(Month) (Day) (Year)

8. AGE: Years 58 Months 2 Days 21 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

12. Name John Fitzgerald  
13. Birthplace St. Louis Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Clarence Wright  
(b) Address 912 DeMun Ave.

17. (a) Burial (b) Date thereof 12-18-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cemetery  
18. (a) Signature of funeral director Robert Donnelle  
(b) Address 3840 Lindell Blvd.

19. (a) DEC 17 1948 (b) J.B. Laster  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis  
(c) City or town Clayton  
(If outside city or town limits, write "RURAL")  
(d) Street No. 912 DeMun Ave.  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 16th.,  
year 1948 hour 7 minute 30 a.m.

21. I hereby certify that I attended the deceased from Oct 17, 1948, to Dec 16, 1948,  
that I last saw him alive on Dec 16, 1948,  
and that death occurred on the date and hour stated above.

Immediate cause of death Lymphosarcoma Diagnosed 11-6-48  
Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy Lymphosarcoma  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(Specify means of injury) \_\_\_\_\_

23. Signature W. H. Hurduth (M. D. or other) M.D.  
Address 4500 Olive Date signed 12-17-48

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

MOTHER FATHER

**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 W. Van Matre

Licensed Embalmer No. 2825

P. O. Address. 4340 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, fact should be so stated above.**