

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5907

FILED MAR 7 1951

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1002** Registrar's No. **1806**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 2620 Howard Street	

3. NAME OF DECEASED (Type or Print) a. (First) Marion b. (Middle) Bright c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Feb. 19 1951		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED* (Specify) Divorced	8. DATE OF BIRTH Aug. 1863		9. AGE (In years last birthday) 88 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction Work		11. BIRTHPLACE (State or foreign country) Liberty, Missouri	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME Harry Bright		13b. MOTHER'S MAIDEN NAME Nina ?		14. NAME OF HUSBAND OR WIFE Irene Bright	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ethel Irvin		ADDRESS 2620 Howard St.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Thrombosis				Undet.	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis				"	
		DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR 332	

22. I hereby certify that I attended the deceased from **2-18**, 19**51**, to **2-19**, 19**51**, that I last saw the deceased alive on **2-19**, 19**51**, and that death occurred at **10:45 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Marion D. Harris		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 2-21-51	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-26-1951		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
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DATE REC'D BY LOCAL REG. FEB 23 1951		REGISTRAR'S SIGNATURE J B Parster		25. FUNERAL DIRECTOR'S SIGNATURE C. J. Hask		ADDRESS 3849 Page	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

over

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.....

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *C. J. Nash*

Licensed Embalmer No. *2432*

P. O. Address *3847 Page*

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.