

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **18725**

No. 300
10-48
LED MAY 19 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4319**

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY _____	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis 2219	
c. LENGTH OF STAY (In this place) _____		d. STREET ADDRESS (If rural, give location) 21 2620 Dickson	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2620 Dickson			

3. NAME OF DECEASED (Type or Print) Minnie Wright			4. DATE OF DEATH. (Month) (Day) (Year) May 4 1952		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH June 7, 1897	9. AGE (In years last birthday) 54 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HR.: Hours _____ Min. _____	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) ARKANSAS	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME Bryant Jones	13b. MOTHER'S MAIDEN NAME Eliza Hodges	14. NAME OF HUSBAND OR WIFE _____
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME Edell Wright - 2620 Dickson	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE GASTRO-ENTERITIS		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input 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) _____
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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? 5711
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22. I hereby certify that I attended the deceased from 5/3, 1952 to 5/8, 1952, that I last saw the deceased alive on 5/3, 1952 and that death occurred at 8:00 P. m., from the causes and on the date stated above.

23a. SIGNATURE Clovis H Beene (Degree or title) _____	23b. ADDRESS 219 E. 4th Jefferson Ave	23c. DATE SIGNED 5/8/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE May 10, 1952	24c. NAME OF CEMETERY OR CREMATORY Green's Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Ill.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 9 1952	25. FUNERAL DIRECTOR'S SIGNATURE English Undertaking Co.	ADDRESS 1123 N. Taylor
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *John K Cunningham*

Licensed Embalmer No. *4476*

P. O. Address *4223 Emig St*

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.