

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **7024**
Registrar's No. **1968**

BIRTH NO. **FILED MAR 8 1954** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: 3325a Lawn Ave.		e. STREET ADDRESS (If rural, give location) 14 3325a Lawn Ave. 2149	
3. NAME OF DECEASED (Type or Print) HARRIET		a. (First) WRIGHT	b. (Middle)
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Feb. 28 1954	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 3, 1902
9. AGE (In years last birthday) 51		10. UNDER 1 YEAR Months	11. UNDER 18 mos. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed by Workmens Service		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Thomas Wright	
13b. MOTHER'S MAIDEN NAME Mary Boyle		14. NAME OF HUSBAND OR WIFE	
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.	
17. INFORMANT'S SIGNATURE OR NAME Marion Wright		ADDRESS 3325a Lawn Ave.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs. ANTECEDENT CAUSES DUE TO (b) Rheumatic heart disease 35 yrs. 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 type="checkbox"/>		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 416X		22. I hereby certify that I attended the deceased from 2-28 1954 to 2-28 1954 , that I last saw the deceased alive on 2-28 1954 , and that death occurred at 10:15 p.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) George A. Make MD		23b. ADDRESS 4161 Lindell Blvd.	
23c. DATE SIGNED 3-2-54		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE Mar. 3, 1954		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	
DATE REC'D BY LOCAL REG. MAR 2 1954		REGISTRAR'S SIGNATURE Carl Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser		ADDRESS 4228 S. Kingshighway Bl.	

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

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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.....
Signature of Student Embalmer

Signed *William B. White*.....

Licensed Embalmer No. *428*.....

P. O. Address *428 N. King*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.