

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10550**
Registrar's No. **2693**

FILED MAR 31 1954 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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

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, Mo.		c. LENGTH OF STAY (In this place) 33 Days	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 1112 N. Newstead	
3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) c. (Last) Wright		4. DATE OF DEATH (Month) (Day) (Year) Mar. 19, 1954	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 7, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (In years last birthday) 74
11. BIRTHPLACE (State or foreign country) Oxford, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Olivia Wright
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Walter C. Wright ADDRESS St. Louis, Mo. 1112 N. Newstead
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Undt.	
ANTECEDENT CAUSES Decubitus Ulcers (Both Feet)			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	
DUE TO (c) Hypostatic Pneumonia			
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 checked="" 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) 260X	
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?	
22. I hereby certify that I attended the deceased from 2-24 , 19 54 , to 3-19 , 19 54 , that I last saw the deceased alive on 3-19 , 19 54 , and that death occurred at 11:35 Am. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) E. B. Williams M.D.		23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 3-22-54
24a. BURIAL, CREMATION, REMOVAL removal	24b. DATE 3/25/54	24c. NAME OF CEMETERY OR CREMATORY Upper Alton	24d. LOCATION (City, town, or county) (State) Alton, Illinois
DATE REC'D BY LOCAL REG. MAR 24 1954	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE W. B. Russell	ADDRESS 1924 Central Alton, Ill.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Joel Russell

Licensed Embalmer No. _____

4112

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.