

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
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 916 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (In this place) 7 days		c. CITY OR TOWN ST. LOUIS		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION Vet. Adm. (Cochran) Hospital				e. STREET ADDRESS (If rural, give location) 3411 Delmar (rear) 2219			
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) M		c. (Last) WRIGHT (Army) WRIGHT (Corp.)		4. DATE OF DEATH (Month) (Day) (Year) 3-31-54			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH 10-15-95	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (City and State or Foreign Country) / ARDMORE, OKLAHOMA	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME UNK		13b. MOTHER'S MAIDEN NAME UNK		14. NAME OF HUSBAND OR WIFE HANNAH WRIGHT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes - W.W.#1		16. SOCIAL SECURITY NO. UNK		17. INFORMANT'S SIGNATURE OR NAME ADDRESS VA HOSP. RECORDS, 916 N. Grand, St. Louis, Mo			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MULTIPLE INFARCTS OF THE LUNGS, KIDNEYS AND SPLEEN ANTECEDENT CAUSES DUE TO (b) MURAL THROMBI OF THE HEART DUE TO (c) RHEUMATIC HEART DISEASE II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH UNK	
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) 416 X			
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?			
22. I hereby certify that I attended the deceased from 3-24-54 , 19___, to 3-31-54 , 19___, that I last saw the deceased alive alive on 3-24-54 3-24-54 , and that death occurred at 4:50 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE [Signature]		b. (Degree or title) M.D.		23b. ADDRESS VET. ADM. HOSP., ST. LOUIS, MO.		23c. DATE SIGNED 3-31-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE April 5, 1954		24c. NAME OF CEMETERY OR CREMATORY National		24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
DATE REC'D BY LOCAL REG. APR 1 1954		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS 1221 N. Grand	

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 *Gupton Swann*.....
Licensed Embalmer No... 458

P. O. Address *221 1/2 Ave*.....

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.