

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21492**
Registrar's No. **4441**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No. 4441	
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 town) St. Louis		c. LENGTH OF STAY (in this place) _____		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 (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Victoria Convalescent				e. STREET ADDRESS (If rural, give location) 5211 Harney			
3. NAME OF DECEASED (Type or Print) a. (First) VAL		b. (Middle) R		c. (Last) WRIGHT		4. DATE OF DEATH (Month) (Day) (Year) May 16 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb 28 1873		9. AGE (In years last birthday) 81	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 2 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (City and State or Foreign Country) Butler Alabama		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME William Wright		13b. MOTHER'S MAIDEN NAME Rebecca		14. NAME OF HUSBAND OR WIFE Mollie Wright			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Fred C Wright 5211 Harney			
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* Carcinoma - Pancreas ANTECEDENT CAUSES Tuberculosis, chronic, corrected. Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Due to (c) II. OTHER SIGNIFICANT CONDITIONS Tuberculosis sclerosis genit. Conditions contributing to the death but not related to the disease or condition causing death. Due to (c)				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 157XA					
22. I hereby certify that I attended the deceased from 3-15-54 to 5-16-54 , that I last saw the deceased alive on 5-14-1954 , and that death occurred at 7:45P m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Charles Brown MD				23b. ADDRESS 16 Plaza Hampden Village		23c. DATE SIGNED 5-18-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 19 54	24c. NAME OF CEMETERY OR CREMATORY St. Matthews		24d. LOCATION (City, town, or county) (State) St. Louis Mo		
DATE REC'D BY LOCAL HEALTH DEPT. MAY 18 1954		REGISTRAR'S SIGNATURE J. Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette			

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 *Joe Ballmer*

Licensed Embalmer No. *401*

P. O. Address *3125 Falls*

**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.**