

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6026**
Registrar's No. **1493**

BIRTH NO. _____ 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 Missouri b. COUNTY Knox	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Knox City	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 City Hospital 0		STREET ADDRESS (If rural, give location) --- 0520,	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Robert	c. (Last) Bright	4. DATE OF DEATH (Month) (Day) (Year) Feb. 15, 1955
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED; NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH May 1, 1871	9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 1 YEAR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Farmer	11. BIRTHPLACE (City and State or Foreign Country) Novelty, Missouri 0	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME David Bright	13b. MOTHER'S MAIDEN NAME Mary (UNKNOWN)	14. NAME OF HUSBAND OR WIFE Eliza Bright
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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. Nil.	17. INFORMANT'S SIGNATURE OR NAME Mrs. M. Rawson,	ADDRESS 1129 So. 10th St.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar Pneumonia		
	ANTECEDENT CAUSES Morbid 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 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H90x
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22. I hereby certify that I attended the deceased from _____ 19____, to _____ 19____, that I last saw the deceased alive on _____ 19____, and that death occurred at **4:40 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Patrick J. Taylor Carver (Degree or title)	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 2.16.55.
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-16-55	24c. NAME OF CEMETERY OR CREMATORY Cochrun Cem.	24d. LOCATION (City, town, or county) (State) Novelty, Mo.
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DATE REC'D BY LOCAL REG. FEB 16 1955	REGISTRAR'S SIGNATURE Carl Smith mo	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington.
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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.....
Signature of Student Embalmer

Signed *W. Wilkinson*

Licensed Embalmer No. *35*

P. O. Address *W. Lan*

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.