

FILED APR 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14064**  
**3106**

BIRTH NO.		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>3106</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>8 8614 Goodfellow</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Gertrude</b> b. (Middle) <b>May</b> c. (Last) <b>Wright</b>			4. DATE OF DEATH <b>April 6, 1955</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 12, 1889</b>	9. AGE (in years last birthday) <b>65</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>William H. Nickels</b>		13b. MOTHER'S MAIDEN NAME <b>Victoria Yeoman</b>		14. NAME OF HUSBAND OR WIFE <b>Cletus O. Wright</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>492-03-8163B</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Cletus O. Wright 8614 Goodfellow</b>			
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) <b>Pulmonary Embolus</b>					INTERVAL BETWEEN ONSET AND DEATH	
	ANTECEDENT CAUSES DUE TO (b) <b>Carcinoma of Cervix with metastases to right lung</b>					<b>4 yrs.</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 <b>4/4/55</b>		19b. MAJOR FINDINGS OF OPERATION <b>As above</b>				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? <b>171X</b>			
22. I hereby certify that I attended the deceased from <b>March 29, 1955</b> , to <b>April 6, 1955</b> , that I last saw the deceased alive on <b>April 6, 1955</b> , and that death occurred at <b>9:10A m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>E. D. Demillion, M.D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>4/6/55</b> (State)	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Apr. 8, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>		24d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		
DATE REC'D BY LOCAL REG. <b>APR 7 1955</b>		REGISTRAR'S SIGNATURE <b>Charles Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>			

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

No. \_\_\_\_\_  
J. Louis \_\_\_\_\_  
Michigan \_\_\_\_\_

Female \_\_\_\_\_  
Date \_\_\_\_\_  
Place \_\_\_\_\_  
Name \_\_\_\_\_  
Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_  
Religion \_\_\_\_\_  
Occupation \_\_\_\_\_  
Cause of Death \_\_\_\_\_  
Date of Death \_\_\_\_\_  
Place of Death \_\_\_\_\_  
Name of Physician \_\_\_\_\_  
Name of Hospital \_\_\_\_\_  
Name of Embalmer \_\_\_\_\_  
Signature of Embalmer \_\_\_\_\_

**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 *Richard W. Storr* \_\_\_\_\_  
Signature of Licensed Embalmer

Licensed Embalmer No. 400

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.