

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 17 1956

State File No. **7437**
Registrar's No. **1113**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1113				
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 OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) 3 yrs.		c. CITY OR TOWN St. Louis		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 Homer G. Phillips Hospital				STREET ADDRESS (If rural, give location) 722 Carpenter				2199a		
3. NAME OF DECEASED (Type or Print) Esther		a. (First) _____		b. (Middle) (Esterlean)		c. (Last) Wright		4. DATE OF DEATH (Month) (Day) (Year) 1 30 56		
5. SEX Fem		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH April 6, 1911		9. AGE (In years last birthday) 44		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Mounds, Illinois		12. CITIZEN OF WHAT COUNTRY? USA				
13a. FATHER'S NAME Charles Wright			13b. MOTHER'S MAIDEN NAME Mattie Johnson			14. NAME OF HUSBAND OR WIFE _____				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Fannie Gholson				ADDRESS 3324 Franklin Avenue	
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Pelvic Abscesses				INTERVAL BETWEEN ONSET AND DEATH Undt.		
				ANTECEDENT CAUSES DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____						
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Resection of Distal Rectum.						
19a. DATE OF OPERATION 12-19-55		19b. MAJOR FINDINGS OF OPERATION Multiple intestinal fistula. Inflammation of distal sigmoid.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) ST. D. 51051		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? 626x						
22. I hereby certify that I attended the deceased from 5-16- , 19 55 , to 1-30- , 19 56 , that I last saw the deceased alive on 1-30- , 19 56 , and that death occurred at 9:50p: m., from the causes and on the date stated above.										
23a. SIGNATURE H. O. Richards				(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier Street		23c. DATE SIGNED 1-31-56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/4/56		24c. NAME OF CEMETERY OR CREMATORY Booker T. Washington		24d. LOCATION (City, town, or county) (State) E. St. Louis, Illinois				
DATE REC'D BY LOCAL REG. FEB 1 1956		REGISTRAR'S SIGNATURE J. C. Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE R. M. C. Green		ADDRESS 4060 Washington Ave				

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 *Melvin E. Green*.....

Licensed Embalmer No. *44*.....

P. O. Address *St. Louis*.....

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.