

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 16 1957

State File No. **34342**
Registrar's No. **7637**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7637	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 15 hours		c. CITY OR TOWN Kirkwood		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 Deaconess Hospital				• STREET ADDRESS (If rural, give location) 27 322 W. Washington Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) EUNICE		b. (Middle) E.		c. (Last) WRIGHT		4. DATE OF DEATH (Month) (Day) (Year) Aug. 14, 1957	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 26, 1911	
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR Months 6		IF UNDER 24 HRS. Days 8 Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) 0		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John Wallace		13b. MOTHER'S MAIDEN NAME Gusta Belew		14. NAME OF HUSBAND OR WIFE Paul Wright			
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. None		17. INFORMANT'S SIGNATURE OR NAME Paul Wright, 322 W. Washington, Kirkwood, Mo. ADDRESS _____			
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* Serous papillary cystadenoma of the ovary ANTECEDENT CAUSES of the ovary 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 Metastases Conditions contributing to the death but not related to the disease or condition causing death. Metastases				INTERVAL BETWEEN ONSET AND DEATH 14 yrs.	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		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) None		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 2-55 8-14-57			
22. I hereby certify that I attended the deceased from May 12, 1955 to Aug 14, 1957 , that I last saw the deceased alive on Aug 14, 1957 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
23a. SIGNATURE Herbert C. Wiegand (Degree or title) Mod.				23b. ADDRESS 3720 Washington		23c. DATE SIGNED 8/15/57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/16/57		24c. NAME OF CEMETERY OR CREMATORY New Hope Cemetery		24d. LOCATION (City, town, or county) (State) Kaiser, Mo.	
DATE REC'D BY LOCAL REG. AUG 15 57		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Louis Hoff, Inc.		ADDRESS Kirkwood Mo.	

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 *Francis J. Wyland Jr.*.....

Licensed Embalmer No. *4512*

P. O. Address *Kirkwood*

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.