

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-027606
STATE FILE NUMBER 6103

FILED JUL 18 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Webster Groves
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp.		Length of stay in lb 1 mo.	d. STREET ADDRESS (If outside, give location) 143 Webster Woods

3. NAME OF DECEASED (Type or print) First Middle Last LETHA BEATRICE WROUGHTON			4. DATE OF DEATH Month Day Year June 13, 1958		
--	--	--	---	--	--

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12, 1890	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
----------	--------------------	---	------------------------------------	------------------------------------	---	------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (City and state or country) Wabash, Ind.	12. CITIZEN OF WHAT COUNTRY? USA
--	--	--	-------------------------------------

13a. FATHER'S NAME Oliver P. Lines	13b. MOTHER'S MAIDEN NAME Lillie Murphy	14. NAME OF HUSBAND OR WIFE Charles C. Wroughton
---------------------------------------	--	---

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 Helen Wroughton, 143 Webster Woods
---	---------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Obstruction of small intestine - post operative</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		<i>5721</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypertensive cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____
---	---

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	_____
---	-------

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	20f. CITY, TOWN, OR LOCATION _____	COUNTY _____	STATE _____
---	---	---------------------------------------	-----------------	----------------

21. I attended the deceased from 1955 to June 13, 1958 and last saw her alive on June 12, 1958
Death occurred at 4:15 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>George W. Stuee, M.D.</i>	22b. ADDRESS <i>600 N. Union Blvd.</i>	22c. DATE SIGNED <i>6-14-58</i>
--	---	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>6-16-58</i>	23c. NAME OF CEMETERY OR CREMATORY <i>White Chapel Mem. Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Detroit, Mich.</i>
---	-----------------------------	---	--

24. FUNERAL DIRECTOR <i>Parker-Aldrich</i>	ADDRESS <i>Webster Groves</i>	25. DATE RECD. BY LOCAL REG. <i>JUN 16 '58</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>
---	----------------------------------	---	---

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

0

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 *Leslie Welch*

Licensed Embalmer No. *4395*
P. O. Address *Walter Grove*

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.