

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-003662

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 23

300  
-57  
25  
124

|  |                           |   |   |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri. b. COUNTY                                       |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>St. Louis, Mo.  |                           | c. CITY OR TOWN St. Louis.  |   |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION<br>St. Johns Hospital  |                           | Length of stay in lb<br>127 STREET ADDRESS<br>4961 Laclede, Ave.  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Eltessia Wright  |                           |   | 4. DATE OF DEATH<br>Month Day Year<br>Jan. 2, 1959                |
| 5. SEX<br>Female   | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br>July 15, 1911                                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Receptionist  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Beauty Salon   | 11. BIRTHPLACE (City and state or country)<br>Nashville, Tenn.    |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                           | 13a. FATHER'S NAME<br>Martin VanBuren Wright  |   |
| 13b. MOTHER'S MAIDEN NAME<br>Ada Owens   |                           | 14. NAME OF HUSBAND OR WIFE<br>Unknown  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br>No. N/A  |                           | 16. SOCIAL SECURITY NO.<br>408-01-7293  | 17. INFORMANT Address<br>Jessica Ford, 4961 Laclede, Ave.         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial ischemia<br>DUE TO (b) Acute intestinal hemorrhage<br>DUE TO (c) Generalized carcinoma of abdomen<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br>Primary granulose cell carcinoma, ovary |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br>4 1/2 hrs<br>34 days<br>6 hrs |
| 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.)<br>1750  |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.  |                           | 20d. INJURY OCCURRED WHILE AT WORK <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 Nov 27-58, Jan 2-58 and last saw her alive on Jan 1-58<br>Death occurred at 12:30AM m on the date stated above; and to the best of my knowledge, from the cause stated.   |                           |   |   |
| 22a. SIGNATURE<br>Draeger M.D.   |                           | 22b. ADDRESS<br>4952 Maryland Ave   |   |
| 22c. DATE SIGNED<br>1/2/59   |                           |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   | 23b. DATE<br>1-2-59       | 23c. NAME OF CEMETERY OR CREMATORY<br>Wood Lawn Cemetery  | 23d. LOCATION (City, town, or county) (State)<br>Nashville, Tenn. |
| 24. FUNERAL DIRECTOR ADDRESS<br>Albert H. Hoppe 4700 Washington Blvd.  |                           | 25. DATE RECD. BY LOCAL REG.<br>JAN 2 59  | 26. REGISTRAR'S SIGNATURE<br>J. Earl Smith M.D.<br>(H.T.)         |

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *G. W. Wilkinson* .....

Licensed Embalmer No. *3578* .....

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.