

MOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **61-047458**

AMENDED

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 3465

FILED DEC 18 1961

| | | | |
|------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 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. Ann | | Length of stay in 1b 50 yrs. | c. CITY OR TOWN St. Ann Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 3878 Geraldine Ave., | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3878 Geraldine Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or print) First Roscoe Middle Dallas Last Wright | 4. DATE OF DEATH Month Dec. Day 6 Year 1961 |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|

| | | | | | | |
|-----------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------|-------------------------------------------|----------------|
| 5. SEX M | 6. COLOR OR RACE W | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 7-15-1893 | 9. AGE (last birthday) 68 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
|-----------------|---------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|----------------------------------|-------------------------------------------|----------------|

| | | | |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10b. KIND OF BUSINESS OR INDUSTRY Farming | 11. BIRTHPLACE (City and state or country) Gasconade, Mo. | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------|

| | | |
|---------------------------------------------|-----------------------------------------------------|-------------------------------------------------------|
| 13a. FATHER'S NAME John M. Wright | 13b. MOTHER'S MAIDEN NAME Mary E. Merican | 14. NAME OF HUSBAND OR WIFE Elsie D. 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. | 17. INFORMANT Address St. Ann Elsie D. Wright 3878 Geraldine |
|-----------------------------------------------------------------------------------------------------------------------|-------------------------|----------------------------------------------------------------------------------|

| | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 3 years |
| DUE TO (b) | | |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |

| | | |
|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 Mar 13, 1957 to Dec. 6, 1961 and last saw him alive on Dec. 1, 1961 Death occurred at 1:30 PM on the date stated above, and to the best of my knowledge, from the causes stated. | | |
| 22a. SIGNATURE Luque J. Canty, M.D. (Degree or title) | 22b. ADDRESS St. Charles, Mo. | 22c. DATE SIGNED Dec. 8, 1961 |

| | | | |
|------------------------------------------------------------|-------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 12-9-1961 | 23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem. | 23d. LOCATION (City, town, or county) (State) St. Ann, Mo. |
|------------------------------------------------------------|-------------------------------|---------------------------------------------------------------|----------------------------------------------------------------------|

| | | |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------|
| 24. FUNERAL DIRECTOR Baumann Bros. Inc. ADDRESS 2504 Woodson Rd., Overland 14, Mo | 25. DATE RECD. BY LOCAL REG. 12-8-61 | 26. REGISTRAR'S SIGNATURE [Signature] |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------|

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 David C. Guba

Licensed Embalmer No. 3454
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.