

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

3313

**1. PLACE OF DEATH**

County.....  
Township.....  
City..... *St. Louis* (No. *924 Taylor*)

Registration District No. *791*  
Primary Registration District No. *1003*

File No. *1*  
Registered No. *940*  
St. .... Ward)

**2. FULL NAME**

(a) Residence. No. *Jesse L. Wright* St. *26* Ward. ....

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Sept 28 - 1908*

7. AGE: YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
*19* | *3* | *26* | *=*

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work *Bricklayer Helper*  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) *Ind*

10. NAME OF FATHER *Emanuel Wright*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Ind*

12. MAIDEN NAME OF MOTHER *Ida Smith*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Ind*

14. INFORMANT *Ms. Ida Cunningham*  
(Address) *924 Taylor St*

15. FILED *Jan 20 1928* *Max C. Starckoff*  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Jan 24 1928*

17. I HEREBY CERTIFY That I attended deceased from *Jan 12 1928* to *Jan 24 1928* that I last saw him alive on *Jan 24 1928* and that death occurred, on the date stated above, at *11:01 p.m.*

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
*Tuber Pneumonia*

CONTRIBUTORY (SECONDARY) *10/10* (duration) yrs. mos. ds. *8*

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? *no* DATE OF.....

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS?  
(Signed) *R. Moore*, M. D.

*1-25*, 19 *28* (Address) *1336 Franklin*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Walhalla* DATE OF BURIAL *1-27 1928*  
ADDRESS

20. UNDERTAKER *Arthur J. Donnelly* *2039 Washor*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD

107 111

1336 France