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

Do not use this space.

26151

791

1003

1. PLACE OF DEATH

County ..... Registration District No. 1003 File No. 7353

Township ..... Primary Registration District No. ..... Registered No. 7353

City St Louis (No. St Lukes Hospital St. ..... Ward)

2. FULL NAME Mrs Edna Wright

(a) Residence. No. 4102 McKee St., ... Ward 18 (If nonresident give city or town and State)
(Usual place of abode)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 28 1903

7. AGE: 25 YEARS, MONTHS: 10, DAYS: 14, If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer At Home

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St Louis Mo

PARENTS

10. NAME OF FATHER Charles Williamson

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

12. MAIDEN NAME OF MOTHER Leuvenia Trower

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

14. INFORMANT Orris Irl Wright (Address) 4102 McKee Ave

15. FILED 15, 19 Max C Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) 7/12 1929

17. I HEREBY CERTIFY, That I attended deceased from 5/10/29, 19..., to 7/12, 1929 that I last saw h. en alive on 7/12, 1929 and that death occurred, on the date stated above, at 11.40 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Embolis during operation for appendectomy & uterus Dilation. Embolism of the Coronary Artery (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Operation for Appendicitis & Retroversion of Uterus (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? 1210

DID AN OPERATION PRECEDE DEATH? DATE OF 1392

WAS THERE AN AUTOPSY? 1945

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) G L Krause, M.D

, 19 (Address) 3720 Washington

*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: Valhalla Cemetery

DATE OF BURIAL: 7-15-1929

20. UNDERTAKER: Kriegshauser Und Co. ADDRESS 4104 Manchester

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.

235

31