

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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

Do not use this space.

16564

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **ST. LOUIS MO.**

(No. **4745 GREER AVE.**)

File No.

5087

Registered No.

St.

Ward)

2. FULL NAME **ROBERT CHARLES WRIGHT,**

(a) Residence. No. **4745 GREER AVE.** St. **7** Ward.

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 **MARRIED**

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **11/29/1863.**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min. **67 4 29.**

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **STATIONARY ENGINEER.** (b) General nature of industry, business, or establishment in which employed (or employer) **TABLER CLEANING & DYEING CO.** (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **ILLINOIS.** (STATE OR COUNTRY)

10. NAME OF FATHER **CHARLES WRIGHT.**

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

12. MAIDEN NAME OF MOTHER **FANNIE TOINBY.**

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

14. INFORMANT **Chas G. Wright** (Address) **4745 Greer Ave.**

15. FILED **311** 19 **1931** **Harley** REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **4/28/31** 19 **31**

17. I HEREBY CERTIFY, That I attended deceased from **Apr. 1** 19**31** to **Apr. 15** 19**31**, and that I last saw him alive on **Apr. 15** 19**31**, and that death occurred, on the date stated above, at **12-30 A.M.**

THE CAUSE OF DEATH* WAS AS FOLLOWS: **Cerebral Apoplexy** **131** **82A** (duration) **1** yrs. **1** mos. **1** ds.

CONTRIBUTORY (SECONDARY) **Chronic Nephritis** (duration) **2** yrs. **2** mos. **2** ds.

18. WHERE WAS DISEASE CONTRACTED **(B)** IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **no** DATE OF **(1)** WAS THERE AN AUTOPSY? **no**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical symptoms** (Signed) **John C. Bruce** M. D. 19 (Address) **4518 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 **ZIONS CEMETERY.** DATE OF BURIAL **4/30/31**

20. UNDERTAKER **Provoost and Co** ADDRESS **9710 N Grand Ave**

