

OCT 14 1937

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

32284

Do not use this space.

1. PLACE OF DEATH

(a) County.....
(b) Township.....
(c) City **Saint Louis**
(e) Length of residence in city or town where death occurred

Registration District No. **791**
Primary Registration District No. **1008**
(d) Street No. **H.G. Phillips Hospital**
(If death occurred in Hospital or Institution, write its name instead of street and number)
Unknown Mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **8338**2. PRINT FULL NAME **Louise Wright**(a) Residence, No. **3723 Cook Avenue** St. **III**

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Negro** 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) **Unknown- 1867**

7. AGE YEARS MONTHS DAYS IF LESS than 1 day,hrs. ormin.
70

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) **August, 1937** 11. Total time (years) spent in this occupation **Unk.**

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unavailable Georgia**FATHER 13. NAME **Unavailable**14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unavailable II**MOTHER 15. MAIDEN NAME **Unavailable**16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unavailable II**17. INFORMANT (ADDRESS) **Mrs. Lee Shoulders 3723 Cook Avenue**18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **Sept. 16, 1937**19. FUNERAL DIRECTOR (ADDRESS) **Charles J. Galt 4107 Finney Avenue**20. FILE **SEP 4 1937** **J. Bredeck** Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 3, 1937**

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to, 19.....

I last saw him..... alive on..... Death is said

to have occurred on the date stated above, at **2:30 P.M.**

The principal cause of death and related causes of importance were as follows:

Aortic Insufficiency and Mitral Stenosis.

Date of onset

Other contributory causes of importance:

Chronic Bronchitis;**Oedema of the Brain**

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? **YES**

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **NO**

If so, specify

(Signed) **Joseph M. Zucchi** M. D.(Address) **1300 Clark Avenue**

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

I - X12004

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.

8992
2
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31

STATEMENT BY LICENSED EMBALMER

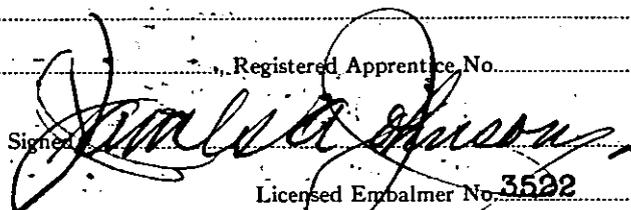
I, James A. Johnson, Licensed Embalmer No. 3522

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Self

L. E.

No. _____ or by _____, Registered Apprentice No. _____
working under my personal supervision.

Signed



Licensed Embalmer No. 3522

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.)