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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 9 1945
318

Registration District No.

Primary Registration District No. 1003

Registrar's No. 1853

1. PLACE OF DEATH:

(a) County.....
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 Mos. 28 days
(Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Tennessee (b) County.....
(c) City or town Jackson
(If outside city or town limits, write "RURAL")
(d) Street No. 426 College St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME LESTER GREEN WRIGHT

3. (b) If veteran, name war No 3. (c) Social Security No.....

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Callie King Wright 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased April 16 1882
(Month) (Day) (Year)

8. AGE: Years 62 Months 10 Days 9 If less than one day
.....hr.min.

9. Birthplace Gibson County, Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Conductor, G.M. & O.R.R. Co.

11. Industry or business Railroad

12. Name James W. Wright

13. Birthplace Tennessee
(City, town, or county) (State or foreign country)

14. Maiden name Belle Biggs

15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Callie King Wright

(b) Address 426 College St., Jackson, Tenn.

17. (a) Burial Removal Date thereof Feb. 27, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Ridgecrest Cemetery Jackson, Tenn.

18. (a) Signature of funeral director Robert J. Ambuster

(b) Address Clayton Rd. at Concord Lane,

19. (a) FEB 26 1945 (Date received local Registrar) J. F. Buesch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 25
year 1945 hour 10 minute 35 A.M.

21. I hereby certify that I attended the deceased from 11/27
1944 to 2/25/45, 19.....
that I last saw him alive on 2/25/45, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Cardiac failure

Due to Ca. of bladder-urinary

Due to Ca. of prostate

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Ca. of bladder
Of autopsy Primary site in bladder.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
.....
(Specify type of place)

While at work?..... (e) Means of injury.....

23. Signature J. Schlenker M. D. or other.....
Address 100 E. Hoop Date signed 2/25/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

JAN 28 1948

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.