

FILED MAY 3 1945

Registration District No. _____ Primary Registration District No. **70013**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital (1)
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7 days**
34 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Earl M. Wright**
3. (b) If veteran, name war _____ 3. (c) Social Security No. **499-10-3847**

4. Sex **Male** 9 5. Color or race **Col** 6. (a) Single, widowed, **married**, divorced
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) **1907** (Year)

7. Birth date of deceased: (Month) **3** (Day) **15** (Year) **1907**
8. AGE: Years **37** Months **7** Days **15** If less than one day hr. _____ min. _____

9. Birthplace: (City, town, or county) **LABOR** (State or foreign country) **9**

10. Usual occupation **LABOR**

11. Industry or business

12. Name **JAMES. WRIGHT**
13. Birthplace **OHIO** (City, town, or county) (State or foreign country)
14. Maiden name **ANNA LUMPKINS**
15. Birthplace **OHIO** (City, town, or county) (State or foreign country)

16. (a) Informant **ANNA LUMPKINS**

(b) Address **4300 LABADIE AVE**

17. (a) **BURIAL** (b) Date thereof **APR 28 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **WASHINGTON PARK**

18. (a) Signature of funeral director **Herman Smith**

(b) Address **4247 N. Labadie Ave.**

19. (a) **APR 24 1945** (b) **J. F. Bredeck**
(Date received for burial) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **17**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL") **710**
(d) Street No. **4300 Labadie** (If rural, give location)
(e) Citizen of foreign country? **0** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **18**, year **1945** hour **8** minute **15 A.** M.

21. I hereby certify that I attended the deceased from **April 11**, 19**45** to **April 18**, 19**45**; that I last saw him alive on **April 18**, 19**45** and that death occurred on the date and hour stated above.

Immediate cause of death **Pulmonary tuberculosis with cavitation** Unk.

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **13**

Major findings: Of operations _____

Of autopsy **Same as above**

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? _____

While at work (Specify type of place) (e) Means of injury **0**

23. Signature **Clara Moore** (M. D. or other) **4/19/45**
Address **Abolwhittier** Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8298

8298

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.....

working under my personal supervision.

James D. Thumson

Registered Apprentice No.....

Signed.....

James D. Thumson

Licensed Embalmer No.....

P. O. Address.....

37122
3506 Franklin

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.

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ (years, months or days)

3. (a) PRINT FULL NAME Carl M. Wright
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 3 1900
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ min.

9. Birthplace Dayton, Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

11. Industry or business _____

12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____
(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____
(b) Address _____

19. (a) MAY 1 1945 (b) J. J. Biseck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day _____ Year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him _____ alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

(b) Date of occurrence _____

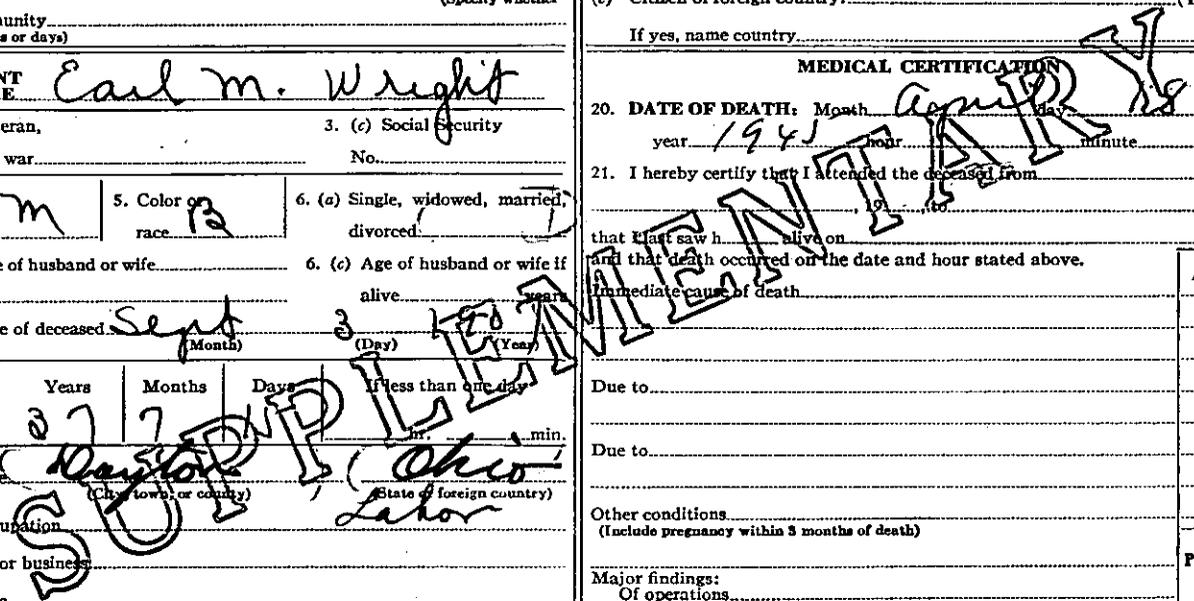
(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____



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

MOTHER FATHER

11965