

S. No. 2
M-5-43
7. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENTRAL REGISTER
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35752**
Registrar's No. **8511**

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis, Missouri
(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:
St. Louis City Hospital - Max C. Starkloff
(If not in hospital or institution, write street number or location) Memorial
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 4206a Castleman
(If rural, give location) Memorial
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME WILL WRIGHT
3. (b) If veteran, name war _____ 3. (c) Social Security No. 406-03-9948

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased November 25th 1868
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 10 6 hr. _____ min.

9. Birthplace Rockport Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Clerk
11. Industry or business Retired

MOTHER, FATHER {
12. Name James Wright 9
13. Birthplace Unknown (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (State or foreign country)

16. (a) Informant Mrs. Bolland
(b) Address 4206a Castleman

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 3 1946
(Month) (Day) (Year)

(c) Place: burial or cremation Rockport Indiana

18. (a) Signature of funeral director Peetz Funeral Home
(b) Address 30825 Lafayette Ave

19. (a) OCT 3 1946 (Date received local registrar) (b) J. F. Bredeek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 1st
year 1946 hour 4:30 minute A M.
21. I hereby certify that I attended the deceased from _____ 19 _____ to October 1st 1946
that I last saw him alive on October 1st 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease with left sided cardiac failure
Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death) 9/3
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) _____ (c) Means of injury W.D.
23. Signature Anna Hyman 1515 Lafayette 10/1/46 (other) _____
Address _____ Date signed _____

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

343274

FILED OCT 16 1946 #39966

NOV 19 1946

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 Ernest W. Spillers

Licensed Embalmer No. 4680

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.