FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15142

BIRTH NO. 25127-50 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3580

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SAINT LOUIS
c. LENGTH OF STAY (in this place): 1hr 45min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SAINT LOUIS MATERNITY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SAINT LOUIS 9119
d. STREET ADDRESS (If rural, give location): 4628 ~~[illegible]~~ ST. FERDINAND 0

3. NAME OF DECEASED (Type or Print)
a. (First): Infant
b. (Middle):
c. (Last): WRIGHT

4. DATE OF DEATH (Month) (Day) (Year): APRIL 13 1950

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): U

8. DATE OF BIRTH: APRIL 13, 1950

9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 1 Min. 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): ST.LOUIS, MISSOURI 0

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: STANLEY GRAY WRIGHT

13b. MOTHER'S MAIDEN NAME: BETTY JEAN SOSEBEE

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: ST. LOUIS MATERNITY HOSPITAL

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral Hemorrhage (pleural effusion) (supp. report)

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April 13, 1950 9:50 am, *to* Apr 13, 1950 11:50 am, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:50 am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Stanley H. Schuman, M.D.

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): (/)

24b. DATE: APR 19 1950

24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: APR 19 1950

REGISTRAR'S SIGNATURE: J. B. Lasater

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Service - 4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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

FILED MAY 1 1950

THE DIVISION OF HEALTH OF MISSOURI

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b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SAINT LOUIS
d. STREET ADDRESS (If rural, give location): 4628 ST. FERDINAND

3. NAME OF DECEASED (Type or Print)
a. (First): Phyllis
b. (Middle): Ann ==Infant==
c. (Last): WRIGHT

4. DATE OF DEATH (Month) (Day) (Year): APRIL 13 1950

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: APRIL 13, 1950
9. AGE (In years last birthday): Months / Days / Hours / Min.: 1 / 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): ST. LOUIS, MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.X.

13a. FATHER'S NAME: STANLEY GRAY WRIGHT
13b. MOTHER'S MAIDEN NAME: BETTY JEAN SOSEBEE
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: ST. LOUIS MATERNITY HOSPITAL

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DUE TO (b) Cerebral hemorrhage (pleural effusion) (supp. report)
DUE TO (c)

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19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr 13, 1950, to Apr 13, 1950, that I last saw the deceased alive on _____, 19__, and that death occurred at 11:30 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Stanley H. Schuman, M.D.
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE: APR 19 1950
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: APR 19 1950
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Service - 4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

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

Item #3 name added by affidavit of mother 9-14-89