

10787

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

Registrar's No. 1937

FILED MAR 24 1952

BIRTH NO. .... REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 20 2720 Elliott avenue	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES		b. (Middle) PAUL	
c. (Last) WRIGHT		4. DATE OF DEATH (Month) (Day) (Year) FEB. 27, 1952	
5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 0	8. DATE OF BIRTH Aug 2nd, 1924
9. AGE (In years last birthday) 27		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Manila, Arkansas	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME James Wright Sr.	
13b. MOTHER'S MAIDEN NAME Lillie Johnson		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Norman Wright, 2720a Elliott ave.		ADDRESS	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Uremia</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Glomerulonephritis</u>  DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from 2-21-52, 19, to 2-27-52, 19, that I last saw the deceased alive on 2-27-52, 19, and that death occurred at 3:50P m., from the causes and on the date stated above.		22. HOW DID INJURY OCCUR? 572X	
23a. SIGNATURE E.J. Catanzaro M.D.		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 2-28-52		24a. BURIAL, CREMATION REMOVAL (Specify) 5	
24b. DATE 2-29-52		24c. NAME OF CEMETERY OR CREMATORY Leachville, Arkansas	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Howard F. H., Leachville, Arkansas	
DATE REC'D BY LOCAL REG. FEB 29 1952		REGISTRAR'S SIGNATURE C. Smith M.D. m 8/3.	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

**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 Ben Goffman.....

Licensed Embalmer No. 4365.....

P. O. Address Spencer, MO......

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.