

S. No. 300  
V. 10.48

14949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 25 1952

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1003

State File No. ....

3103

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		_____		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>3311 Laclede</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sam</u> b. (Middle) <u>Frank</u> c. (Last) <u>Wright</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 30 1952</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Apr 2 1893</u>		
9. AGE (In years last birthday) <u>58</u>		10. MONTH <u>11</u>		11. DAY <u>28</u>		12. HOUR <u>11</u> MIN. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			11. BIRTHPLACE (State or foreign country) <u>Ark</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Willie Wright</u>	
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. <u>490-18-8538</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Willie Wright</u> ADDRESS <u>110 A no Theresa</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Meningo-vascular Lues</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>None</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>026 X</u>				
22. I hereby certify that I attended the deceased from <u>3-23</u> , 19 <u>52</u> , to <u>3-30</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>3-30</u> , 19 <u>52</u> , and that death occurred at <u>4:30p</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>Lois M. Harris</u> (Degree or title) <u>M. D. O.</u>				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>3-31-52</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr 5-52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>APR 2 1952</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.W. Hughes</u> ADDRESS <u>2620 Lawton</u>				

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

(Licensed Embalmer's Statement on Reverse Side)

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.

Student Embalmer No. ....

Signed \_\_\_\_\_

*James A. Porter*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4681*

P. O. Address *H 923 Suburban*

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.