

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10-48

U.S. APR 25 1952

BIRTH NO. _____ REG. DIST. NO. **918** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3385**

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Springfield	
c. LENGTH OF STAY (In this place) 53 Days		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Dolan b. (Middle) S. c. (Last) Wrightsmen			4. DATE OF DEATH (Month) (Day) (Year) 4 10 52		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH March 3, 1902		9. AGE (In years last birthday) 50		IF ORDER IN RES. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Mattress Mfg.		11. BIRTHPLACE (State or foreign country) Springfield, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME William Henry Smith		13b. MOTHER'S MAIDEN NAME Mary Jane West		14. NAME OF HUSBAND OR WIFE Lawrning Wrightsmen	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Dorothy Langstaff ADDRESS 2498 W. Florida	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION Denver, Colo.				INTERVAL BETWEEN ONSET AND DEATH 20 Years	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Portal Cirrhosis		DUE TO (b) _____					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 58/0	

22. I hereby certify that I attended the deceased from **2-16**, 19**52**, to **4-10**, 19**52**, that I last saw the deceased alive on **4-10**, 19**52**, and that death occurred at **5:05a.** m., from the causes and on the date stated above.

23a. SIGNATURE [Signature] (Degree or title) no.		23b. ADDRESS Barnes Hospital		23c. DATE SIGNED 4-10-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-10-52		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Springfield, Mo.	
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DATE REC'D BY LOCAL REG. APR 10 1952		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.	
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

APR 21 1953

NOT STAMPED

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 Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, 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.