

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

30210

State File No. ....

7841

FILED SEP 3 - 1952

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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 <b>Missouri</b> b. COUNTY <b>2199</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>4378 Forest Park</b>		d. STREET ADDRESS (If rural, give location) <b>19 4378 Forest Park</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Lillian</b> b. (Middle) <b>Catherine</b> c. (Last) <b>Wright</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 18, 1952</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>Oct. 30, 1878</b>	
9. AGE (In years last birthday) (Specify) <b>73</b>		10. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Greene Co., Ark.</b>	
12. COUNTRY OF WHAT COUNTRY? <b>U.S.</b>		13a. FATHER'S NAME <b>J.F. Foster</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Billie K. Wright</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Warren Wright, 4378 Forest Park</b>		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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> <b>Left side paralyzed</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b> DUE TO (b) <b>Pernicious Anaemia</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b> <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 years</b>	
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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) <input checked="" type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>2900X</b>	

22. I hereby certify that I attended the deceased from May 19 50, to Aug. 18 1952, that I last saw the deceased alive on Aug. 17 1952, and that death occurred at 7a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>ROY STANFIELD</b>		23b. ADDRESS <b>Chambers Bldg</b>		23c. DATE SIGNED <b>8/18/52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8-19-52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Lynnwood</b>	
24d. LOCATION (City, town, or county) (State) <b>Paragould, Ark.</b>					

DATE REC'D BY LOCAL REG. <b>AUG 18 1952</b>		REGISTRAR'S SIGNATURE <b>Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	
				ADDRESS <b>4700 Washington Blvd.</b>	

(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 \_\_\_\_\_

*Fred J. Farmer*

Licensed Embalmer No. 4788

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.