

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44557

FILED DEC 17 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11660**

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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4067a Hartford Ave		d. STREET ADDRESS (If rural, give location) 4067a Hartford Ave	

3. NAME OF DECEASED (Type or Print) Sarah Belle Wright		4. DATE OF DEATH Dec 8 1953	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 23 1869
9. AGE (In years last birthday) 84		10. MONTHS 8 DAYS 1 HOURS 0 MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Asteria Ills.	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME James Gregory	13b. MOTHER'S MAIDEN NAME Amenda Turner	14. NAME OF HUSBAND OR WIFE Samuel B. Wright
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Patti King
15. ADDRESS (If yes, give war or dates of service)		17. ADDRESS 4067a Hartford Ave

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		INTERVAL BETWEEN ONSET AND DEATH 7	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility			?
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Gen. arteriosclerosis			
DUE TO (c) Ch. myocarditis		?		
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 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 4221

22. I hereby certify that I attended the deceased from **6-1-1953** to **12-8-1953**, that I last saw the deceased alive on **12-1-1953**, and that death occurred at **7 A.M.** m., from the causes and on the date stated above.

23a. SIGNATURE W. J. Heine, M.D.	(Degree or title)	23b. ADDRESS 5203 Oliveview	23c. DATE SIGNED 12/9/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Dec 11 1953	24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cent.	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.

DATE REC'D BY LOCAL REG. DEC 10 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Weick Bros	ADDRESS 2201 S. Grand Blvd.
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5, p. (Licensed Embalmer's Statement on Reverse Side)

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

5203 Chilpewa

Fl. 6670

2 to 4 Daily

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 J. Allen Rapis
Licensed Embalmer No. 4957
P. O. Address Haus

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.