

FILED JAN 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **45635**  
**12209**  
Registrar's No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>Ferguson</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place)		e. STREET ADDRESS (If rural, give location) <b>RR 10 Box 686</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>ELIZABETH</b> b. (Middle) <b>(NMN)</b> c. (Last) <b>WRIGHT</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>DECEMBER 26, 1953</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Dec. 27, 1916</b>	9. AGE (In years last birthday) <b>36</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 Hrs. Hours	IF UNDER 15 Mins. Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>ST. Louis Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>Mo</b>		

13a. FATHER'S NAME <b>Moritz J. Bernhardt</b>	13b. MOTHER'S MAIDEN NAME <b>ANNA ISTHWAN</b>	14. NAME OF HUSBAND OR WIFE <b>Louis A. Wright</b>
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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. <b>489-12-5645</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Louis A. Wright</b>	ADDRESS <b>RR #10 Ferguson Mo</b>
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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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>A TELECTASIS</b>		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>BILATERAL HYDROTHORAX</b>			
DUE TO (c) <b>SUB-DIAPHRAGMATIC ABSCESS</b>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>10-16-53</b>	19b. MAJOR FINDINGS OF OPERATION <b>Myomatous uterus and left ovarian cyst</b>	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>576X</b>

22. I hereby certify that I attended the deceased from 10-29, 1953, to 12-26, 1953, that I last saw the deceased alive on 12-26, 1953, and that death occurred at 8:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE <b>JR Pradey</b> (Degree or title) <b>M.D.</b>	23b. ADDRESS <b>BARNES HOSPITAL</b>	23c. DATE SIGNED <b>12-26-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	24b. DATE <b>12-29-1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Lake Wood Park Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>7801 Genesta Ave Mo.</b>
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DATE REC'D BY LOCAL REG. <b>DEC 28 1953</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>M. Ziegenhein</b>	ADDRESS <b>Broad 6409 Gravois</b>
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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.....  
Signature of Student Embalmer

Signed.....  
*John M. Symon*

Licensed Embalmer No. 434

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.