No. 300
10-48

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29331

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7520

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A.Homer G. Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐

e. STREET ADDRESS (If rural, give location): 5276 Page Blvd. 205 9/0

3. NAME OF DECEASED (Type or Print)
a. (First): OLICE
b. (Middle): WILBERT
c. (Last): WRIGHT

4. DATE OF DEATH (Month) (Day) (Year): Aug. 11 1954

5. SEX: Male 2
6. COLOR OR RACE: Col.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: July 18, 1913
9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months 0, Days 23 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Alloy Bronze Co.
11. BIRTHPLACE (City and State or Foreign Country): Webster Groves, Mo. 0
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: William Wright
13b. MOTHER'S MAIDEN NAME: Rachel ?
14. NAME OF HUSBAND OR WIFE: Flossie Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.#II
16. SOCIAL SECURITY NO.: yes
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Flossie Wright 526 King St., Kinloch, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Concussion; Aspiration of Blood; suffered when struck with fist or unknown object in hands of one James Burley during scuffle in home at 5276 a Page Ave. about 130 am Aug 11th 1954 Manslaughter

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Manslaughter
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): St Louis Mo

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 11 54 1 30 A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? E983 X

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 155A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M. Quinn Deputy Coroner
23b. ADDRESS: 1300 Clark
23c. DATE SIGNED: 8/14/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Aug. 17, 1954
24c. NAME OF CEMETERY OR CREMATORY: National
24d. LOCATION (City, town, or county) (State): Jefferson Barracks Mo.

DATE REC'D BY LOCAL REG.: AUG 14 1954
REGISTRAR'S SIGNATURE: J. Earl Smith M.D. E.P.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. H. RANDLE & SON 3133 Bell Ave.

(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 embal

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Esther K. Harris

Licensed Embalmer No. 4 4

P. O. Address 481 Mas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fail 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.