

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023555

STATE FILE NUMBER

2 5501

FILED JUN 18 1959

Registration District No.

Primary Registration District No.

Registrar's No.

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300
1-57
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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Saint Charles Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Length of stay in 1b 1 mo.	d. STREET ADDRESS (If outside, give location) 1218 No. 2nd St. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Edward C. Wright			4. DATE OF DEATH Month Day Year June 7, 1959		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1917	9. AGE (In years last birthday) 42	10. FUNDING YEAR Months 5 Days 3	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat breaker	10b. KIND OF BUSINESS OR INDUSTRY metal	11. BIRTHPLACE (City and state or country) Troy, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Edward D. Wright	13b. MOTHER'S MAIDEN NAME Bertha Carter	14. NAME OF HUSBAND OR WIFE Velma Hamm
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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) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Address Mrs. Velma Wright, St. Charles, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hydromyelia of cervical cord and brain stem</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Pneumonia, severe hyposecalosis 3441</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <i>5-5-59</i> to <i>6-7-59</i> and last saw her/him alive on <i>6-5-59</i> Death occurred at <i>9 p.m.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Ernest H. Schaefer, M.D.</i>	22b. ADDRESS <i>7200 Manchester St. Louis</i>	22c. DATE SIGNED <i>6-9-59</i>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE June 10, 1959	23c. NAME OF CEMETERY OR CREMATORY Troy Cemery	23d. LOCATION (City, town, or county) (State) Troy, Missouri
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24. FUNERAL DIRECTOR H.C. Dallmeyer & Sons	ADDRESS St. Charles, Mo	25. DATE RECD. BY LOCAL REG. JUN 9 '59	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use every standard notification in their jurisdiction. All diseases in Part I must be causally related.

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 *Jean R. Malon*
Licensed Embalmer No. *4837*
P. O. Address *H. Charles*

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.