

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042747

FILED VS NOV 20 1959

210207

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>18 Years</b>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Deaconess Hosp.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3008 Magnolia Ave.</b>

3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>ALLINE</b> Last <b>WRIGHT</b>	4. DATE OF DEATH Month <b>Nov.</b> Day <b>4,</b> Year <b>1959</b>
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5. SEX <b>F. D</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/1909</b>	9. AGE (last birthday) <b>50</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>Madison County Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Thomas Franklin</b>	13b. MOTHER'S MAIDEN NAME <b>Mary E. Abernathy</b>	14. NAME OF HUSBAND OR WIFE <b>Chester 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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Chester Wright</b>	Address <b>3008 Magnolia Ave.</b>
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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) <b>Re-marrriage from ruptured liver and spleen, infiltrating the entire abdominal cavity</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Suffered when struck by tomb stone in Fredericktown, Missouri</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Under names of injury in PART I or PART II, if any) <b>in Fredericktown, Missouri</b>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <b>10:29 AM</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>75 Cemetery</b>	20f. CITY, TOWN, OR LOCATION <b>Fredericktown Mo.</b>	COUNTY _____ STATE _____
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21. I attended the deceased from \_\_\_\_\_ and last saw her alive on \_\_\_\_\_  
Death occurred at **250 P.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i>	22b. ADDRESS <b>1300 Oak</b>	22c. DATE SIGNED <b>11/6/59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<b>Removal Auto</b>	<b>11/6/1959</b>	<b>Hill View Memorial Cem</b>	<b>Farmington, Missouri</b>

24. FUNERAL DIRECTOR <b>Raymond Caldwell &amp; Son Flat River Mo.</b>	25. DATE RECD. BY LOCAL REG. <b>NOV 6 1959</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed John E. McCulloch

Licensed Embalmer No. 2760

P. O. Address 6175 1/2 W. 11th St.

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