

JURY DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JAN 29 1960

211878

STATE FILE NUMBER
-59-047068

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 3 Days	c. CITY OR TOWN St. Louis, Mo.		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 6244 Oakland Ave.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle H. Last WRIGHT			4. DATE OF DEATH Month Dec. Day 21, Year 1959		
5. SEX M	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1890	9. AGE (last birthday) 69	IF UNDER 1 YEAR Months 4 Days 5 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Equipment		10b. KIND OF BUSINESS OR INDUSTRY Manufacturers Agt.		11. BIRTHPLACE (City and state or country) Munising, Mich.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME Robert H. Wright		13b. MOTHER'S MAIDEN NAME Anna Marie O'Donnell	
14. NAME OF HUSBAND OR WIFE Bertha Wright (dec.)		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. 395-05-4358	
17. INFORMANT Joyce Wright Miler		Address 825 Parkside Pittsburgh, Pa.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Hypertension Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 331x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 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	
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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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	
21. I attended the deceased from Nov. 20 1954 to Dec. 21, 1959 and last saw him alive on Dec. 21, 1959 Death occurred at 12:15 on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE D. E. Williamson M.D. (Degree or title)			22b. ADDRESS 6336 Clayton Road		22c. DATE SIGNED 12-22-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Dec. 22, 1959	23c. NAME OF CEMETERY OR CREMATORY Floral Hill, Cem.		23d. LOCATION (City, town, or county) (State) New London, Wisc.
24. FUNERAL DIRECTOR A. H. Bocklage ADDRESS 6536 Clayton Rd.			25. DATE RECD. BY LOCAL REG. DEC 22 1959		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.

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 Harvey Kable

Licensed Embalmer No. 4596

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.