

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County.....

Registration District No.....

**791**

Township.....

Primary Registration District No.....

**1003**

City *St. Louis* (No. ....)

File No.....

**31626**

Registered No. **8966**

St. .... Ward)

**2. FULL NAME**

*Perrettta Scott*

(a) Residence. No. *423 S. Garrison* St.,

(Usual place of abode)

*18* Ward.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX *Female*

4. COLOR OR RACE *Col*

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *9-18-1901*

7. AGE

YEARS *26*

MONTHS

DAYS *16*

If LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) *Ark*

(STATE OR COUNTRY)

10. NAME OF FATHER *Marshall Jones*

PARENTS

11. BIRTHPLACE OF FATHER (CITY OR TOWN) *La*

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER *Katie Scafe*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) *La*

(STATE OR COUNTRY)

14.

INFORMANT *Richard Scott*

(Address) *423 S. Garrison*

15.

FILED *7*

1927

*Man E. Starks*

REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/4 1927*

17.

I HEREBY CERTIFY, That I attended deceased from *Aug 16*, 19*27*, to *Oct 4*, 19*27* that I last saw h. *er* alive on *Oct 1*, 19*27*, and that death occurred, on the date stated above, at *9:30 a.* m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

*Adv. Tuberculosis*  
*2 1/2 yrs* (duration) yrs. *3* mos. ds.

CONTRIBUTORY (SECONDARY) *3/1* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED *at home*

IF NOT AT PLACE OF DEATH, DATE OF

DID AN OPERATION PRECEDE DEATH? *no* DATE OF

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Chinice*

(Signed) *Vincent J. Munn, M. D.*

(Address) *2335 Franklin*

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Brookman Washington Cem.*

DATE OF BURIAL *10/9 1927*

20. UNDERTAKER *J. M. Green*

ADDRESS *3517 S. Sibley*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

