

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

Do not use this space.

32537

**1. PLACE OF DEATH**

County..... Registration District No. **791**  
 Township..... Primary Registration District No. **1003**  
 City **Saint Louis** (No. **Masoni Home**) St. .... Ward)

File No. ....  
 Registered No. **9644**

**2. FULL NAME**

**Mrs. Wilhelmina Scott**  
 (a) Residence. No. **5351 Delmar** St. **12** Ward. ....  
 (Usual place of abode) (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 **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Widowed**

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William H Scott**

7. DATE OF BIRTH (MONTH, DAY AND YEAR) **Feb 7 1843**  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
**86 7 21**

8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work **retired housewife**  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Jennings County**  
 (STATE OR COUNTRY) **Indiana**

10. NAME OF FATHER **Harman Steining**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Unknown**  
 (STATE OR COUNTRY) **Unknown**

12. MAIDEN NAME OF MOTHER **Sophia West**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Unknown**  
 (STATE OR COUNTRY) **Unknown**

14. INFORMANT **Mrs. W. Waller**  
 (Address) **5351 Delmar St Louis**

15. **29 1929** FILED **29 1929** **Max L Starckoff** REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) **Sept 28 1929**

17. I HEREBY CERTIFY, That I attended deceased from **July 11 1929** to **Sept 28 1929** that I last saw her alive on **Sept 27 8:45 P.M.** and that death occurred, on the date stated above, at **8:45 P.M.**

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

**Chronic Myocarditis**  
**P3E**  
 (duration) yrs. **6** mos. ds.

CONTRIBUTOR (SECONDARY) **P3E**  
 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?  
 IF NOT AT PLACE OF DEATH.....

0 DID AN OPERATION PRECEDE DEATH? **No** DATE OF.....

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Phys Ex only**  
 (Signed) **Robert Carson** M. D.

**Apr 28 1929** (Address) **Metropolitan Bldg**

\*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 **New St. Marcus** DATE OF BURIAL **10-1-1929**

20. UNDERTAKER **Ziegenhein Bros. 26236 Peroker** ADDRESS

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.

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