

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. **6731**

1. PLACE OF DEATH: **1003** **REC'D SEP 14 1939**
 (a) County _____
 (b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2823 Knox Ct.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)
 In this community **Most of life**

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County _____
 (c) City or town **28th St. Louis, Mo.** 3
(If outside city or town limits, write "RURAL")
 (d) Street No. **2823 Knox Ct.**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME **Mrs. Minnie Scott**
 8. (b) If veteran, name war **None**
 8. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**
 6. (b) Name of husband or wife **Late Joseph Scott** 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **AUG 22 1858**
(Month) (Day) (Year)

8. AGE: Years **80** Months **11** Days **9** If less than one day _____ hr. _____ min.

9. Birthplace **Somerset Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Invalid**

11. Industry or business _____

MOTHER FATHER
 { 12. Name **Unknown Muir** **9**
 { 13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)
 { 14. Maiden name **Unknown** **9**
 { 15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs Charles Prizier**
 (b) Address **2823 Knox Ct.**

17. (a) **Burial** (b) Date thereof **8-3-39**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Volhalla Cemetery**

18. (a) Signature of funeral director **Kriegshauser Mortuaries**
 (b) Address **4228 So. Kingshighway**

19. (a) **AUG 1 1939** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **July** day **31**
 year **1939** hour **10** minute **AM** M.

21. I hereby certify that I attended the deceased from **July 27 1939** to **July 31 1939**
 that I last saw him alive on **July 29 1939**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Cholerae dysenteriae**
intermittent
 Due to **renal changes**
 Due to _____

Other conditions **renal changes**
(Include pregnancy within 3 months of death)
 Major findings: _____
 Of operations: _____
 Of autopsy: _____

PHYSICIAN
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

23. Signature **John Douglas** (M. P. or other) **MD**
 Address **708 N Grand** **8/31/39**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

DR. JOHN CONNORS
Metrop Bldg.

12³⁰ to 3 P.M.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed Edwin M. Bernatt
Licensed Embalmer No. 3024
P. O. Address.....

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 this body is not embalmed, above space should be left blank.