

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31196**
Registrar's No. **8259**

Registration District No. **791**

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH: **1003**
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Homer Phillips
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since 6/8/39
(Specify whether In this community _____ years, months or days)

3. (a) PRINT FULL NAME Frank Scott
(b) If veteran, name war no
(c) Social Security No. None

4. Sex M 5. Color or race C
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ludora Scott
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased June 16, 1882
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
57 3 6 hr. min.

9. Birthplace Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation nil Blind

11. Industry or business _____

MOTHER FATHER
12. Name Ambrose Scott
13. Birthplace Alabama
(City, town, or county) (State or foreign country)
14. Maiden name Clara Jenkins
15. Birthplace Arkansas
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ludora Scott

(b) Address 4208 Piney Ave St. Louis, Mo

17. (a) burial (b) Date thereof 9-27-39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cemetery

18. (a) Signature of funeral director Jas. H. Randle
(b) Address 335 Belle Avenue

(c) Date received local registrar SEP 26 1939

(d) Registrar's signature J. B. Bruck

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 1
(c) City or town St. Louis **21**
(If outside city or town limits, write "RURAL")
(d) Street No. 2731 Lawton
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 22
year 1939 hour 1 minute 25 p. M.

21. I hereby certify that I attended the deceased from 6/8/39
19____ to 9/22/39, 19____;
that I last saw him alive on 9/22/39, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cystitis Tubercular **abt 3 1/2 mos**
Duration _____

Due to --
Due to -- **25**

Other conditions Ruptured bladder (urinary) **abt 2 1/2 hr**
(Include pregnancy within 3 months of death)

with peritonitis Tubercular **PHYSICIAN**

Major findings:
Of operations _____
Of autopsy --
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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature H. J. Pymon (M. D. of MISSOURI)

Address 2601 N. Whittier Date signed 9/26/39

WHITE PLAIN—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.

I X 1931

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 myself

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

W. H. Houston Jr.

..... Licensed Embalmer No. 22667

P. O. Address 2817, Thomas, E.

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.