

23-1981  
 1 X 1981  
 WHILE I REMAIN - USE DIVIDING 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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 37160-1  
Registrar's No. 1853

Registration District No. 784 Primary Registration District No. 200

1. PLACE OF DEATH: 1850 NOV 9 1959  
 (a) County ST LOUIS  
 (b) City or town KOCH  
 (c) Name of hospital or institution: KOCH HOSPITAL  
 (d) Length of stay: In hospital or institution 470 days  
 In this community Same years, months or days

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County 1  
 (c) City or town ST LOUIS  
 (d) Street No. 3137 Caroline  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years

3. (a) PRINT FULL NAME CYRUS SCOTT  
 (b) If veteran, name war None  
 (c) Social Security No. None

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month October day 17  
 year 1959 hour 9 minute 50 P.M.

4. Sex Male 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Widower  
 6. (b) Name of husband or wife Lillie Smith  
 6. (c) Age of husband or wife if alive deceased years  
 7. Birth date of deceased February 19 1906  
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from July 1, 1957, to October 17, 1959;  
 that I last saw him alive on October 17, 1959;  
 and that death occurred on the date and hour stated above.

8. AGE: Years 53 Months 7 Days 28  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Chronic pulmonary tuberculosis 6 yrs  
 Duration \_\_\_\_\_

9. Birthplace ST LOUIS MISSOURI  
 (City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
 Due to 73

10. Usual occupation laborer

Other conditions (Includes pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business Trucking and hauling

Major findings: Of operations \_\_\_\_\_

MOTHER FATHER { 12. Name FRANK SCOTT

Of autopsy \_\_\_\_\_

13. Birthplace MISSOURI  
 (City, town, or county) (State or foreign country)

Underline the cause to which death should be charged statistically.

MOTHER FATHER { 14. Maiden name NANCY SCOTT

15. Birthplace MISSOURI  
 (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
 (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

16. (a) Informant's own signature deceased  
 (b) Address 3137 Caroline

(b) Date of occurrence \_\_\_\_\_

17. (a) Burial (b) Date thereof 10/23/59  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(c) Place: burial or cremation E. St. Louis Ill

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director [Signature]  
 (b) Address 5517 S. Claude Ave

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of Injury \_\_\_\_\_

23. Signature Clyde R. Miller (M. D. or other) \_\_\_\_\_  
 Address Koch, Missouri Date signed 10-18-59

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**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.

Signature

*(F. M. Green)*

Licensed Embalmer No. *1173*

P. O. Address *3517 Soledad Ave*

**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.**