

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 19451

Registration District No. 784

Primary Registration District No. 100

Registrar's No. 1019

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Gouldowrth Nursing Home
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Ada B. Scott

3. (b) If veteran, name war _____

3. (c) Social Security No. 307

4. Sex Female

5. Color or race W.

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife John M. Scott

6. (c) Age of husband or wife if alive (Deed) years

7. Birth date of deceased July 10th, 1856
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
83	10	16	hr. _____ min.

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

10. Usual occupation Housework

11. Industry or business _____

MOTHER FATHER

12. Name Hugh Steuart

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

14. Maiden name Elizabeth Duncan

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

16. (a) Informant Chester Scott

(b) Address Chesterfield Mo.

17. (a) Burial (b) Date thereof 5-29-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Friedens Cemetery

18. (a) Signature of funeral director Probst

(b) Address 3710 W. Grand Blvd.

19. (a) MAY 27 1940 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Chesterfield
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 26th.
year 1940 hour 9.30 minute A. M.

21. I hereby certify that I attended the deceased from May 16th, 1940, to May 23, 1940; that I last saw her alive on May 23, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death lobar pneumonia Duration 2 days

Due to _____

Due to _____

Other conditions Senility
(Include pregnancy within 3 months of death) 15 years

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? 701

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

23. Signature [Signature] (M. D. or other) _____

Address 3651 Grand Square Date signed 5-27-40

Dr. M...
3651
Remained...
12 30 7...

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 me

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

Signed Robert L. Burkman

Licensed Embalmer No. 3553

P. O. Address 3710 N. Grand Bl

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.