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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 20 1945

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 727

Primary Registration District No. 1003

Registrar's No. 333

1. PLACE OF DEATH:

(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: Masonic Home Infirmary
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5381 Delmar Ave
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME John Edgar Scamell

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race Wh

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

6. (b) Name of husband or wife Clarissa Scamell

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased January (Month) 9 (Day) 1872 (Year)

8. AGE: Years 73 Months 0 Days 2 If less than one day hr. min.

9. Birthplace New Haven (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER

12. Name Benjamin Scamell

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

14. Maiden name Julia Francis

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

16. (a) Informant Mrs Clarissa Scamell

(b) Address Masonic Home Infirmary

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 15 '45 (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Kraeger-Voss-Fix

(b) Address 3402 No. Kingshighway

19. (a) JAN 12 (Date received local registrar) (b) 1945 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 11th year 1945 hour 9 minute P. M.

21. I hereby certify that I attended the deceased from Nov. 25, 1944, to Jan. 11th, 1945, 19; that I last saw him alive on Jan. 11, 1945; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 weeks
Due to Hypertension	2 years
Due to	
Other conditions (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:

(c) 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? (Specify type of place)

While at work? (e) Means of injury?

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

Address 508 N. Grand Blvd. Date signed 1/12/45

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.