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DEPARTMENT OF HEALTH  
BUREAU OF THE CENSUS  
STANDARD CERTIFICATE OF DEATH

State File No. **11641**  
Registrar's No. **2280**

**FILED** MAR 20 1946  
Registration District No. **318**

Primary Registration District No. **1003**

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: Homer Phillips Hosp.  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 Hrs.  
(Specify whether)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME Nona Scott

3. (b) If veteran, name war ----

3. (c) Social Security No. None

4. Sex Female 5. Color or race Negro

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

6. (b) Name of husband or wife James Scott

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

7. Birth date of deceased August 6th 1881  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>64</u>	<u>7</u>	<u>1</u>	<u>    </u> hr. <u>    </u> min.

9. Birthplace Valley Park Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ----

MOTHER FATHER { 12. Name James Thompson

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

14. Maiden name Maggie Robinson

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

16. (a) Informant John Thompson

(b) Address 4448 West Belle Pl.

17. (a) Burial (b) Date thereof 3/11/46  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director Charles J. Gates

(b) Address 4107 Finney Ave.

19. (a) MAR 8 1946 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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. 2636 Baldwin St.  
(If rural, give location)

(e) Citizen of foreign country?      (Yes or No)  
If yes, name country     

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7th  
year 1946 hour 6:15 minute A.M. M.

21. I hereby certify that I attended the deceased from     , 19     to     , 19    ;  
that I last saw h.      alive on     , 19    ;  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Atherosclerosis

Due to     

Due to     

Other conditions       
(Include pregnancy within 3 months of death)

Duration     

PHYSICIAN     

Underline the cause to which death should be charged statistically.

Major findings:     

Of operations     

Of autopsy     

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 [Signature] (a)      (b)       
(Specify type of place) (c) Means of injury

Address 1300 Clark Ave. Date signed

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.....

Thomas J. Gates

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

*Thomas J. Gates*

Licensed Embalmer No. 5259

P. O. Address. 4107 Finney 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, fact should be so stated above.**