

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **39076**
Registrar's No. **9511**

FILED NOV 25 1946
318
Registration District No. _____

Primary Registration District No. _____

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

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 34 hours (Specify whether
In this community 18 YEAR
years, months or days)

3. (a) PRINT FULL NAME Alabama Scott

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 3 5. Color or race C 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if

7. Birth date of deceased. MAR 16 1894
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
52 7 16 hr. min.

9. Birthplace. ARK. 1
(City, town, or county) (State or foreign country)

10. Usual occupation. HOUSE WORK

11. Industry or business _____

12. Name DUB BELCHA

13. Birthplace ARK 1
(City, town, or county) (State or foreign country)

14. Maiden name CORLE STRINER

15. Birthplace ARK 1
(City, town, or county) (State or foreign country)

16. (a) Informant OTTO EPPERSON

(b) Address 3123 THOMAS

17. (a) Burial (b) Date thereof Nov 7 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation GREENWOOD

18. (a) Signature of funeral director F. A. GREEN

(b) Address 2915 FRANKLIN

19. (a) NOV 7 1946 (b) J. Z. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 915 N. CARDINAL
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2
year 1946 hour 10 minute 8 P. M.

21. I hereby certify that I attended the deceased from 11-1 19 46 to 11-2 19 46
that I last saw h. er alive on November 2 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death
Hypertensive Encephalopathy
Hypertensive Heart Disease

Duration
Undet.

Due to _____
Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy No

PHYSICIAN
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)
(c) Means of injury _____

23. Signature E. B. Williams (M. D. or other) _____
Address 2601 N. Whittier Date signed 11/4/46

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

J. A. Green

Licensed Embalmer No.

2963

P. O. Address

2915 Franklin

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.