

FILED FEB 3 1947

318

Primary Registration District No. _____

1003

Registrar's No. 522

1. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town St. Louis
 (c) Name of hospital or institution Alexian Bros. Hospitals
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME John J. Scott

3. (b) If veteran _____ name war _____
 3. (c) Social Security No. 491-12-9118

4. Sex Male 5. Color W
 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mary
 6. (c) Age of husband or wife if alive 70 years
 7. Birth date of deceased October 14 1871
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>75</u>	<u>3</u>	<u>3</u>	hr. min.

9. Birthplace St. Louis Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Maintenance Man
 11. Industry or business Benjamin Moore Paint Co.

12. Name Phillip Scott

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

14. Maiden name Ruth Betty

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

16. (a) Informant Joseph E. Scott

(b) Address 5105 2 Minerva

17. (a) Burial Calvary (b) Date thereof 1-20-47
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director Charles J. Smart
 (b) Address 1225 Union Blvd.

19. (a) JAN 19 1947 (b) J. F. Bremer
 (Date local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis
 (c) City or town St. Louis
 (d) Street No. 515 2 Minerva
 (e) Citizen of foreign country? _____ (Yes or No) _____
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17
 year 1947 hour 5:45 minute _____ A. M.
 21. I hereby certify that I attended the deceased from Jan 10th
1947, 19____, to Jan. 17th 1947
 that I last saw him alive on Jan. 16th 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Cardiac Failure Duration 1 day

Acute Bronchiectasis with Pulmonary Hemorrhage 6 days

Due to Generalized Arterio-Sclerosis indefinite

Due to Aneurysm of abdominal Aorta Indefinite

Other conditions Bi-lateral Inguinal Hernia
 (Include pregnancy within 3 months of death)

Major findings: No surgery 9/6
 Of operations _____

Of autopsy Abd. Aorta Aneurysm Scrotal hernia colonic Gen. Arterio-Sclerosis Pul. Bronchiectasis

22. If death was due to external causes, fill in the following: Acute
 (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)
 Means of injury _____

23. Signature George J. Mehan MD (M. D. or other) _____
 Address 3906 Olive St Date signed 1-17-

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

MOTHER FATHER

3903 Blue
J. Wilkin

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: W. Wilkin
Licensed Embalmer No. 3575
P. O. Address.....

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.