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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 3 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1008

3100
State File No. _____
Registrar's No. 795

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 122 days
In this community Life
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Ocie Lee Scott
3. (b) If veteran, name war _____
3. (c) Social Security No. 487-32-2805

4. Sex Male 5. Color or race Negro
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JAN 18 1925
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
22 2 _____ hr. _____ min.

9. Birthplace Saint Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation LABORER

11. Industry or business _____

12. Name Walter Scott

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

14. Maiden name W. A. Farrell

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

16. (a) Informant FRANCES TODD

(b) Address 3335 MARKET ST

17. (a) BURIAL (b) Date thereof 1-25-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Mary Hale

(b) Address 4202 Finney Ave.

19. (a) JAN 23 1947 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County _____
(c) City or town St Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 3335 Market St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month January day 20
year 1947 hour 5 minute 40 A.M.

21. I hereby certify that I attended the deceased from December 29, 1946 to January 20, 1947
that I last saw her alive on January 20, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Far-Advanced Pulmonary Tuberculosis
Duration Unk

Due to _____
Due to _____

Other conditions [Signature]
(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:

(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) (e) Means of injury _____

23. Signature E. B. Millman (M. D. or other) _____

Address 2601 N Whittier St Date signed 1-21-47

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

MOTHER-FATHER

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. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *45-75 Aldine*

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.