No. 2
-1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED SEP 15 1947

Registration District No. 3/7

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3063

State File No. 29747

Registrar's No. 1921

1. PLACE OF DEATH:
(a) County: ST. LOUIS COUNTY
(b) City or town: CRAYTON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ST. LOUIS COUNTY HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 8 DAYS (Specify whether years, months or days)
In this community: 74 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO. (b) County: ST. LOUIS CO.
(c) City or town: LEMAY
(If outside city or town limits, write "RURAL")
(d) Street No.: 197 KINGSTON
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: MARY E. SCOTT
3. (b) If veteran, name war:
3. (c) Social Security No.:

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: MARRIED
6. (b) Name of husband or wife: HENRY
6. (c) Age of husband or wife if alive: 84 years
7. Birth date of deceased: AUG. (Month) 24 (Day) 1873 (Year)

8. AGE: Years 74 Months 0 Days 13 If less than one day: hr. min.

9. Birthplace: ST. LOUIS CO. (City, town, or county) MO. (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: ISAAC ODELL
13. Birthplace: (City, town, or county) ILL. (State or foreign country)
MOTHER
14. Maiden name: JULIA McCREE
15. Birthplace: (City, town, or county) PA. (State or foreign country)
16. (a) Informant: SAMUEL SCOTT
(b) Address: 124 SIGSBEE
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: SEPT. 10-47 (Month) (Day) (Year)
(c) Place: burial or cremation: MT. OLIVE CEM.
18. (a) Signature of funeral director: E. H. Blomenkamp & Co.
(b) Address: 7814 S. Broadway
19. (a) 9-11-47 (Date received local registrar) (b) Leila Kloster (Registrar's signature) MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEP. day 7 year 1947 hour 7 minute 15 P.M.
21. I hereby certify that I attended the deceased from AUG. 30, 1947, to SEP. 7, 1947, that I last saw her alive on SEP. 7, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Cerebral vascular accident.	8 days
Due to: Hypertensive Cardio Vascular Disease	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: none.
Of autopsy: none

PHYSICIAN
Underline the cause of 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? (Specify type of place)
While at work: (e) Means of injury:
23. Signature: R. L. Herdener (M. D. or other)
Address: 601 BRENTWOOD BLVD. Date signed: 9/8/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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

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 Louis C. Hoffmann

Licensed Embalmer No. 3871

P. O. Address 7814 S. Broadwa

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.

No. 2B
I—3-45
P I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 317 Primary Registration District No. 3063 Registrar's No. 1921

1. PLACE OF DEATH:

(a) County St Louis

(b) City or town Clayton
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Mary E Scott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 24 (Month) (Day) (Year)

8. AGE: Years 74 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country) N/O

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 7 year 1947 hour minute 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

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

5-29747