V. S. No. 2
50M—1/47
Rev. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 33003

FILED SEP 18 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 8477

WRITE PLAINLY—USING 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 4256 Enright Ave.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community 10 Days
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Texas ri (b) County

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

(d) Street No. 2319 Lorraine St.
(If rural, give location)

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

N.R.

If yes, name country

3. (a) PRINT FULL NAME Celia A. 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

6. (b) Name of husband or wife Dr. Wm. H. Scott

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

7. Birth date of deceased Unavailable (Month) (Day) 1872 (Year)

8. AGE: Abt Years 75 Months Days If less than one day hr. min.

9. Birthplace Booneville (City, town, or county) Tennessee (State or foreign country)

10. Usual occupation Housewife

11. Industry or business ---

FATHER
12. Name Adam Phelps
13. Birthplace Newberry (City, town, or county) N. Carolina (State or foreign country)

MOTHER
14. Maiden name Harriet ---Unk.
15. Birthplace Unavailable (City, town, or county) Tennessee (State or foreign country)

16. (a) Informant Uxenia Livingston
(b) Address 4256 Enright Ave.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-6-47 (Month) (Day) (Year)
(c) Place: burial or cremation Houston, Texas

18. (a) Signature of funeral director Charles J. Gates
(b) Address 4107 Finney Ave.

19. (a) SEP 6 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4th year 1947 hour 9:00 minute P,M M.

21. I hereby certify that I attended the deceased from August 27 1947 to Sept. 4 1947 that I last saw her alive on September 1 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Occlusion	Terminal
Due to Arteriosclerosis	Unknown
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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 [signature] (M. D. or other)

Address 11 N. Jefferson Ave. Date signed 9-5-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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. 4259

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.