

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6788

State File No.

FILED MAR 4 1954

318

1003

Registrar's No. 0301

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission).
a. STATE Missouri b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) St Louis c. LENGTH OF STAY (in this place) _____
c. CITY OR TOWN St Louis d. Is Residence within limits of a city or incorporated town? Yes No 2/19

d. FULL NAME OF HOSPITAL OR INSTITUTION 107 No. CHANNING
e. STREET ADDRESS (If rural, give location) 21 107 No Channing

3. NAME OF DECEASED (Type or Print) a. (First) ALFRED b. (Middle) J c. (Last) SCOTT 4. DATE OF DEATH (Month) (Day) (Year) JAN 9th 1954

5. SEX Male 6. COLOR OR RACE NEGRO 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 8. DATE OF BIRTH 30 JUNE 32 9. AGE (In years last birthday) 21 6 Months 6 Days 9 If UNDER 1 YEAR If UNDER 24 HRS. Hours 9 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber 10b. KIND OF BUSINESS OR INDUSTRY Car Wash 11. BIRTHPLACE (City and State or Foreign Country) St Louis MO 12. CITIZEN OF WHAT COUNTRY? U S

13a. FATHER'S NAME UNKNOWN 13b. MOTHER'S MAIDEN NAME Mildred SCOTT 14. NAME OF HUSBAND OR WIFE ANN SCOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 492-30-8651 17. INFORMANT'S SIGNATURE OR NAME ADDRESS ANN SCOTT 107 No Channing

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES DUE TO (b) Gunshot wound of skull and brain, self inflicted in his home, about 7:30pm DUE TO (c) January 9, 1954 II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION Suicide 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis MO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan 9 54 7:30 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? E976X

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:54 a.m., from the causes and on the date stated above.

22a. SIGNATURE (Degree or title) Patrick E Taylor Coroner 23b. ADDRESS 1300 Clark 23c. DATE SIGNED 1-12-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE 14 Jan 54 24c. NAME OF CEMETERY OR CREMATORY OAKdale Cemetery 24d. LOCATION (City, town, or county) (State) St Louis MO

DATE REC'D BY LOCAL REG. JAN 12 1954 REGISTRAR'S SIGNATURE Carl Smith 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Carl Smith Reliable Funeral Svs Inc 4500 Newberry Terrace

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, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Paul V. Freeman*

Licensed Embalmer No. *4686*

P. O. Address *4729 Hwy*

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**