

FILED AUG 2 - 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25215**
Registrar's No. **6674**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. STATE Missouri c. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. CITY OR TOWN St Louis | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital | | e. STREET ADDRESS (If rural, give location) 3115 Marnice Pl. | |

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| 3. NAME OF DECEASED (Type or Print) Lenora | a. (First) | b. (Middle) | c. (Last) Scott | 4. DATE OF DEATH (Month) (Day) (Year) July 14, 1954 |
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| 5. SEX Female | 6. COLOR OR RACE wh | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH July 14, 1874 | 9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months 1 | IF UNDER 24 HRS. Hours --- Min. --- |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and State or Foreign Country) Arkansas | 12. CITIZEN OF WHAT COUNTRY? Yes | | | |

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| 13a. FATHER'S NAME Nesley Powers | 13b. MOTHER'S MAIDEN NAME Anna Dunn | 14. NAME OF HUSBAND OR WIFE Dead |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Miss Ethel Scott | ADDRESS 3115 Marnice |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Carcinoma of the Stomach with Metastasis | | Undt |
| | ANTECEDENT CAUSES DUE TO (b) Morbid conditions, as any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 151X |

22. I hereby certify that I attended the deceased from **May 24, 1954**, to **July 14, 1954**, that I last saw the deceased alive on **July 14, 1954**, and that death occurred at **8:15 P.m.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Carl Belle Smith, M.D. | 23b. ADDRESS 2601 N. Whittier | 23c. DATE SIGNED 7/19/54 |
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|--|--------------------------|---|---|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 7/19/54 | 24c. NAME OF CEMETERY OR CREMATORY Greenwood | 24d. LOCATION (City, town, or county) (State) St Louis County MO |
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| DATE REC'D BY LOCAL REG. JUL 20 1954 | REGISTRAR'S SIGNATURE Carl Belle Smith | 25. FUNERAL DIRECTOR'S SIGNATURE W. H. Newman | ADDRESS 447 7th St. St. Louis |
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(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, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
W. Charles Gardner

Licensed Embalmer No. 348

P. O. Address 45750

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.