

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10498

State File No. \_\_\_\_\_

FILED APR 4 1955

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 541 Registrar's No. 672

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>St Louis</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u> |  | c. CITY OR TOWN <u>Clayton</u> <u>4468</u>  |  |
| c. LENGTH OF STAY (in this place) <u>18 yrs.</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>             |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>45 Aberdeen Place</u>                            |  | STREET ADDRESS (If rural, give location) <u>45 Aberdeen Place</u>   |  |

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|---|--|---|---|--|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>George</u> b. (Middle) <u>Catherine</u> c. (Last) <u>Scott</u> |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>3 21 55</u> |  |  |
| 5. SEX <u>female</u>  |  | 6. COLOR OR RACE <u>white</u>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>        |  |
| 8. DATE OF BIRTH <u>May 26, 1871</u>  |  | 9. AGE (In years last birthday) <u>83</u>                             |   | IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired head of</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Old Spokesman Publishing Co.</u> |   | 11. BIRTHPLACE (City and State or Foreign Country) <u>Danville, Missouri</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |   |   |  |  |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 13a. FATHER'S NAME <u>John C. Ellis</u> |  | 13b. MOTHER'S MAIDEN NAME <u>Anna Porter</u> |  | 14. NAME OF HUSBAND OR WIFE <u>Robert Law Scott</u> |  |
|---|--|--|--|---|--|

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|---|--|-------------------------------------|--|--|--|
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> |  | 16. SOCIAL SECURITY NO. <u>unk.</u> |  | 17. INFORMANT'S SIGNATURE OR NAME <u>Calvin H. East</u> ADDRESS <u>45 Aberdeen Place</u> |  |
|---|--|-------------------------------------|--|--|--|

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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardites - Chronic</u><br>ANTECEDENT CAUSES<br>DUE TO (b) <u>Atherosclerosis</u><br>DUE TO (c) <u>Age</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>18 months</u><br><u>8 years</u> |  |
|---|--|--|--|--|--|

|                        |  |                                  |  |  |  |
|------------------------|--|----------------------------------|--|--|--|
| 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)<br><u>4221</u> |  |
| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR?                                     |  |

22. I hereby certify that I attended the deceased from July 1, 1954, to March 21, 1955, that I last saw the deceased alive on March 21, 1955, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

|  |  |   |  |                                     |  |
|--|--|---|--|-------------------------------------|--|
| 23a. SIGNATURE <u>W. E. Jones M.D.</u> (Degree or title) |  | 23b. ADDRESS <u>110 South Central - Clayton</u> |  | 23c. DATE SIGNED <u>March 22-55</u> |  |
|--|--|---|--|-------------------------------------|--|

|  |  |                          |  |   |  |  |  |
|--|--|--------------------------|--|---|--|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u> |  | 24b. DATE <u>3-22-55</u> |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u> |  | 24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u> |  |
|--|--|--------------------------|--|---|--|--|--|

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. <u>5/22/55</u> |  | REGISTRAR'S SIGNATURE <u>Richard K. Romberg</u> |  | FUNERAL DIRECTOR'S SIGNATURE <u>C. R. Lupton &amp; Sons</u> ADDRESS <u>7233 Delmar Blv'd.</u> |  |
|---|--|---|--|---|--|

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

1000 M

✓ 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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*  
P. O. Address *St. Louis*

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.