

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **24347**  
**6423**

BIRTH NO. **60945255** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>	
c. LENGTH OF STAY (In this place) <b>1 Day</b>		d. STREET ADDRESS (If rural, give location) <b>5 5176 Vernon</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hosp.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Barbara</b>		b. (Middle) <b>Ann</b>	
		c. (Last) <b>Scott</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>7 4 55</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>7-2-55</b>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min. <b>1 4 49</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>0</b>			
13a. FATHER'S NAME <b>Lexington Scott</b>		13b. MOTHER'S MAIDEN NAME <b>Earline Dean</b>	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		INFORMANT'S SIGNATURE OR NAME <i>Wm. H. Shepherd</i>	
		ADDRESS <b>C.R.L. 2601 N. Whittier</b>	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Premature Birth - Neonatal Death</b>	
		INTERVAL BETWEEN ONSET AND DEATH	
		II. ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____	
		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 <b>7735</b>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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)		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 <b>7-2, 1955</b> , to <b>7-4, 1955</b> , that I last saw the deceased alive on <b>7-4, 1955</b> , and that death occurred at <b>4:00pm.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <i>William H. Shepherd, M.D.</i>		23b. ADDRESS <b>2601 N. Whittier</b>	
23c. DATE SIGNED <b>7-7-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <b>7-30-55</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		24d. LOCATION (City, town, or county) (State) <b>Rowland-Aker Mortuary Service</b>	
DATE REC'D BY LOCAL REG. <b>JUL 26 1955</b>		REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	
25. FUNERAL DIRECTOR'S SIGNATURE		25b. ADDRESS <b>St. Louis 10, Mo.</b>	

*mg* (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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

**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.