

FILED JAN 26 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **3000**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **322**

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 town or township) <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (in this place)		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 <b>BARNES HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>5211 WEST MINSTER PL.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Oren</b> b. (Middle) <b>E.</b> c. (Last) <b>Scott</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 9, 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>Nov. 11, 1871</b>
9. AGE (In years last birthday) <b>84</b>		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Realtor</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Mc PLETT AND TOWN TOWN U.S.A.</b>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>REAL ESTATE</b>	12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME <b>CLARK B. SCOTT</b>		13b. MOTHER'S MAIDEN NAME <b>KATHREN GILMORE</b>	14. NAME OF HUSBAND OR WIFE <b>MABEL CRABBE SCOTT</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>498-12-8661</b>	
17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. L.A. BLUE</b>		ADDRESS <b>5112 WEST MINSTER</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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Dissecting Aneurysm</b>  ANTECEDENT CAUSES DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Myasthenia Gravis</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>451x</b>	
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) (Minute)	
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>1943</b> , 19 to <b>Jan. 9, 1956</b> , that I last saw the deceased alive on <b>Jan. 9, 1956</b> , and that death occurred at <b>11:25 AM</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>C. O. Vermillion, M.D.</b> (Degree or title) <b>M. D.</b>		23b. ADDRESS <b>BARNES HOSPITAL</b>	
23c. DATE SIGNED <b>1/9/56</b>		24. BIRTHAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
24b. DATE <b>JAN-12-1956</b>		24c. NAME OF CEMETERY OR CREMATORY <b>BELLEFONTAINE CEM.</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>C.R. Guppon &amp; Sons</b>	
25. ADDRESS <b>2233 DELMAR BLVD.</b>		DATE REC'D BY LOCAL REG. <b>JAN 10 1956</b>	

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 7 1961

**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. Schoen*

Licensed Embalmer No. *386*

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.