

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42595

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **11297**

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>St. Genevieve</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Mary's</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Booth Memorial</b>		Length of stay in lb <b>3 days</b>		d. STREET ADDRESS <b>Box 109</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Corinne</b> Middle <b>C</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>23</b> Year <b>1957</b>				
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 9, 1900</b>		9. AGE (In years last birthday) <b>57</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>15</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frank Gamache</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia Chatron</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Louis Scott, St. Mary's Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Vascular Heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Polyp of stomach</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>4 mo</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>4214</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <b>July 1 57</b> to <b>Nov 23-57</b> and last saw her <b>live on Nov 23/57</b> Death occurred at <b>7007</b> m on the date stated above; and to <b>the best of my knowledge, from the causes stated.</b>								
22a. SIGNATURE <b>J. S. [Signature]</b> (Degree or title) _____				22b. ADDRESS <b>2752' Church</b>		22c. DATE SIGNED <b>11/20/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>11/26/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Immaculate Conception</b>		23d. LOCATION (City, town, or county) (State) <b>St. Mary's Mo.</b>			
24. FUNERAL DIRECTOR <b>Fendler Und. Co.</b> ADDRESS <b>7420 Michigan</b>			25. DATE RECD. BY LOCAL REG. <b>NOV 25 57</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

*Dr. H. Payne*  
*2752 Cherokee*  
*1:30 Mon.*

St. Louis, Mo. Booth Temporary 3 days X  
 St. Mary's St. Louis, Mo. X  
 Nov. 23, 1927 Scott X  
 Sept. 9, 1900 Scott X  
 USA St. Louis, Mo. At Home X  
 Frank Gamache St. Louis, Mo. X  
 No. No. No.

**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. G. Peterson*  
 Licensed Embalmer No. *370*  
 P. O. Address *7420th*

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.

Embalmer License No. 7420th