Health, & Welfare . Public h Service

S. 300 v. 1-56

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 JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 46320

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12594

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL — Length of stay in 1b 18	d. STREET ADDRESS 4350 Chouteau (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: PEARL	Middle: H.	Last: SCOTT	4. DATE OF DEATH: Month December, Day 28, Year 1957
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 6-10-1903	9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundress	10b. KIND OF BUSINESS OR INDUSTRY: General Diaper	11. BIRTHPLACE (City and state or country): Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: William Nealy		14. MOTHER'S MAIDEN NAME: Rose Moreland		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT: Tim Scott, 4350 Chouteau	Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to above cause (a) stating the underlying cause last. DUE TO (b) 12/30/57

DUE TO (c) 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 12/27/57, to 12/28/57 and last saw her/him alive on 12/28/57. Death occurred at 9:10 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) M. D.

22b. ADDRESS BARNES HOSPITAL

22c. DATE SIGNED 12/29/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 12-31-1957

23c. NAME OF CEMETERY OR CREMATORY: Lakewood Park Cem.

23d. LOCATION (City, town, or county) (State): St. Louis Co., Missouri

24. FUNERAL DIRECTOR: McLAUGHLIN'S, 2301 Lafayette — ADDRESS

25. DATE RECD. BY LOCAL REG.: DEC 30 57

26. REGISTRAR'S SIGNATURE: H Carl Smith MD

(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 emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4 5

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.