

Health, Welfare, Public Service

300  
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

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46630

STATE FILE NUMBER

FILED DEC 30 1957

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3223

|  |                                       |  |   |
|--|---------------------------------------|--|---|
| 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>IRON</u>                  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/><br>OR TOWN <u>CLAYTON</u>  |                                       | c. CITY OR TOWN <u>GOODLAND</u> - Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                      |   |
| c. FULL NAME OF (If NOT in hospital, give location) Length of stay in 1b<br>HOSPITAL OR INSTITUTION <u>ST LOUIS CO HOSPITAL</u> <u>D.O.A.</u>  |                                       | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br><u>RURAL</u>         |   |
| 3. NAME OF DECEASED (Type or print) <u>EFFIE</u> First <u>MAY</u> Middle <u>SCOTT</u> Last   |                                       | 4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>57</u>  |   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-1-1890</u> 69   |
| 9a. AGE (In years last birthday) <u>67</u>   |                                       | 9b. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   | 9c. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>   | 11. BIRTHPLACE (City and state or country) <u>GOODLAND MISSOURI</u>                         |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                       | 13. FATHER'S NAME <u>JAMES MERRITT</u>   |   |
| 14. MOTHER'S MAIDEN NAME <u>HARRIET MCCLAIN</u>  |                                       | 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>NONE</u>  |                                       | 17. INFORMANT Address <u>Ralph SCOTT 135 DEAN, GT. KIRKWOOD 22 MO</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u> years <u>4000</u><br>DUE TO (c) <u>4000</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>thyrotoxicosis</u> |                                       |  | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>   |
| 19a. ACCIDENT <input type="checkbox"/>   | 19b. SUICIDE <input type="checkbox"/> | 19c. HOMICIDE <input type="checkbox"/>   | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20a. TIME OF INJURY Hour <u>5</u> a. m. <u>30</u> p. m.  |                                       |  | 20b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)   |
| 20c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                                       | 20d. CITY, TOWN, OR LOCATION <u>GOODLAND</u> COUNTY <u>IRON</u> STATE <u>MISSOURI</u>  |   |
| 21. I attended the deceased from <u>11-20-56</u> to <u>12-19-57</u> and last saw her alive on <u>12-12-1957</u><br>Death occurred at <u>5:30</u> A.M. on the date stated above; and to the best of my knowledge, from the causes stated.   |                                       |  |   |
| 22a. SIGNATURE <u>Charles Miller M.D.</u>  |                                       | 22b. ADDRESS <u>206 N. Clay, Kirkwood Mo.</u>  | 22c. DATE SIGNED <u>12-20-57</u>  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>   | 23b. DATE <u>12-57</u>                | 23c. NAME OF CEMETERY OR CREMATORY <u>HERROD CEMETERY</u>  | 23d. LOCATION (City, town, or county) (State) <u>DESLUGE MISSOURI</u>                       |
| 24. FUNERAL DIRECTOR <u>EARL H. NEMAN</u> ADDRESS <u>9709 BLACKLAND RD</u>   |                                       | 25. DATE RECD. BY LOCAL REG. <u>12-20-57</u>   | 26. REGISTRAR'S SIGNATURE <u>Herbert D. Donke M.D.</u>                                      |

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.....  
*Paul G. Hillman*

Licensed Embalmer No. 350

P. O. Address *Orland*

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.