

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007603

STATE FILE NUMBER

FILED MAR 10 1959

Registration District No. Primary Registration District No. Register No. 21706

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mississippi b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis		c. CITY OR TOWN Louin	
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St Louis Little Rock Hosp Inc		d. STREET ADDRESS (If outside, give location) General Del	

3. NAME OF DECEASED (Type or print) First Audes Middle Reagan Last Scarborough	4. DATE OF DEATH Month Feb Day 17 Year 59
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28 1903	9. AGE (In years last birthday) 55	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Mississippi	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME WILLIAM SCARBOROUGH	14. MOTHER'S MAIDEN NAME EDNA PENNINGTON
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 718,05,4610	17. INFORMANT Address LOUIN AUDIE SCARBOROUGH MISSISSIPPI
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT - PERITONITIS DUE TO (b) RECURRENT CARCINOMA - COLON C DUE TO (c) METASTASIS - LUNGS - THYROID 1538 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

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 Dec 29, 58 to Feb 17, 59 and last saw her alive on Feb 17, 59
Death occurred at 11:15 am m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) J. J. Hanyka M.D. C	22b. ADDRESS 1755 So Grand	22c. DATE SIGNED 18 Feb 59
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL FEB. 1959	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY DECATUR CEMETERY	23d. LOCATION (City, town, or county) (State) DECATUR MISSISSIPPI
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24. FUNERAL DIRECTOR Kutis Funeral Home	ADDRESS 2906 Gravois Ave. St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. 2-17-1959	26. REGISTRAR'S SIGNATURE Road Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by _____, Student Embalmer No. _____
working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed Eleanore Poivine

Licensed Embalmer No. 34

P. O. Address John

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