

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-011787  
STATE FILE NUMBER

FILED APR 14 1959

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 904

300  
-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Rockhill</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Rockhill</b> <b>4631</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>428 Lone Oak Dr</b>		Length of stay in lb <b>6 Years</b>	d. STREET ADDRESS (If outside, give location) <b>428 Lone Oak Dr</b>
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Pickering</b> Last <b>Scott</b>			4. DATE OF DEATH Month <b>March</b> Day <b>31</b> Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1871</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>88</b> 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) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. NAME OF FATHER'S NAME <b>Thomas Jefferson Pickering</b>	
13b. MOTHER'S MAIDEN NAME <b>Sarah Belle Lee</b>		14. NAME OF HUSBAND OR WIFE <b>Henry Clingan 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>None</b>	17. INFORMANT <b>Mr Harmon S. Klinger 428 Lone Oak Dr</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>Carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Fractured Left Humerus</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <b>Myocardial Infarction</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1964</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 _____ a.m. _____ p.m. Month, Day, Year _____			
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>6-1-58</b> to <b>3-31-59</b> and last saw her alive on <b>3-31-59</b> Death occurred at <b>S. Spaulding Home</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Carl L. Buetow</b> (Degree or title)		22b. ADDRESS <b>227 E. Lockwood St</b>	22c. DATE SIGNED <b>4-1-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>4/2/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co, Missouri</b>
24. FUNERAL DIRECTOR <b>Alexander &amp; Sons 6175 Delmar Blv</b>		25. DATE RECD. BY LOCAL REG. <b>4-3-59</b>	REGISTRAR'S SIGNATURE <b>John L. Murphy, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

Dr. Carl Irick  
227 East Lockwood  
Wo. 1-2960  
1 to 2 P.M.

**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 *Jos. McCullough* .....

Licensed Embalmer No. *2760* .....

P. O. Address *617 1/2 Pl...* .....

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.