

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016084

STATE FILE NUMBER

DECEASED MAY 8 1959 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 1208

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before a. STATE Missouri b. COUNTY St. Louis)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Clayton		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Overland 423 1/2
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. L. County Hosp.		Length of stay in lb 3 wks.	d. STREET ADDRESS (If outside, give location) 9205 E. Milton Ave.
3. NAME OF DECEASED (Type or print) First Frank Middle Miller Last Scott		4. DATE OF DEATH Month 5 Day 2 Year 59	
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 Apr. 30, 1909
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (City and state or country) Labadie, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Elias Scott	
13b. MOTHER'S MAIDEN NAME Elva Moore		14. NAME OF HUSBAND OR WIFE Imogene Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or years of service) yes W.W.#2		16. SOCIAL SECURITY NO. 497-05-2794	17. INFORMANT Address Imogene Scott, 9205 E. Milton Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Brain DUE TO (b) Adenocarcinoma of Small Intestine DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Malnutrition			INTERVAL BETWEEN ONSET AND DEATH
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.) 1529	
20c. TIME OF INJURY Hour _____ 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 4-8-59 to 5-2-59 and last saw him alive on 5-2-59 Death occurred at 4:55 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Miss M. Page M.D.	
22b. ADDRESS 601 So. Brentwood		22c. DATE SIGNED 5-2-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-4-1959	23c. NAME OF CEMETERY OR CREMATORY Fee Fee Cemetery	23d. LOCATION (City, town, or county) (State) Bridgeton, Missouri
24. FUNERAL DIRECTOR Baumann Bros. Inc. Overland, Mo.		25. ADDRESS 2504 Woodson Rd.	26. DATE RECD. BY LOCAL REG. 5-2-59
27. REGISTRAR'S SIGNATURE John C. Murphy M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *David C. Gibson*

Licensed Embalmer No. *3054*

P. O. Address *Overland*

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.