

**R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-013192**

**FILED VS MAR 24 1960**

**2 2728**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Hemer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>1435 Franklin</b>	

<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Thomas Scott</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>1 20 60</b>		
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<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/> <b>Separated</b>	<b>8. DATE OF BIRTH</b> <b>8-6-1898</b>	<b>9. AGE (last birthday)</b> <b>61</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HR</b> Hours Min.
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<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Unknown</b>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (City and state or country) <b>Louisiana</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A</b>
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<b>13a. FATHER'S NAME</b> <b>Abe Scott</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Mary</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Unknown</b>
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<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>	<b>16. SOCIAL SECURITY NO.</b> <b>Unknown</b>	<b>17. INFORMANT</b> <b>Mrs. Mary D. Jett, R.R. 1 2601 N. Whittier</b>
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<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Stomach</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>15H</b>	
	DUE TO (c)	

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
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<b>20c. TIME OF INJURY</b> Hour a.m. p.m.	<b>20d. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20e. CITY, TOWN, OR LOCATION</b>	<b>20f. COUNTY</b>	<b>20g. STATE</b>
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<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)	<b>20f. CITY, TOWN, OR LOCATION</b>	<b>20g. COUNTY</b>	<b>20h. STATE</b>
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**21. I attended the deceased from** **1-8-60** to **1-20-60** and last saw <sup>her</sup>him alive on **1-20-60**  
Death occurred at **10:50 a.** m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <i>Howard Q. Emmer</i>	<b>22b. ADDRESS</b> <b>2601 N. Whittier St.</b>	<b>22c. DATE SIGNED</b> <b>2-4-60</b>
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<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>MAR 8 1960</b>	<b>23b. DATE</b> <b>MAR 8 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Anatomical Board</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis, Mo.</b>
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<b>24. FUNERAL DIRECTOR</b> <b>Rawland Aka 4104 Manchester</b>	<b>25. DATE RECD. BY LOCAL REG.</b> <b>MAR 8 1960</b>	<b>26. REGISTRAR'S SIGNATURE</b> <i>Earl Smith M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Student \_\_\_\_\_ Signed \_\_\_\_\_  
Signature of Student Embalmer

Licensed Embalmer No. \_\_\_\_\_  
 P. O. Address \_\_\_\_\_

**STATEMENT BY LICENSED EMBALMER**

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