

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

9435

-61-039206

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ -

ITEM NO.

Registration District No. 318  
 Primary Registration District No. 1003  
 Registrar's No. 9435

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>20 years</u>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>5075 Raymond</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Queen Esther Scott</u>			4. DATE OF DEATH Month Day Year <u>10 10 61</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>4/20/1919</u>	9. AGE (last birthday) <u>42</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cooks</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	11. BIRTHPLACE (City, and state or country) <u>Ark.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Governor Marshall</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Tooke</u>	14. NAME OF HUSBAND OR WIFE <u>Disceat</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>	17. INFORMANT Address <u>Mildred R. Scott, 511 West home ark</u>
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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) <u>Hypertensive Cardiovascular Disease</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>443 x</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uremia</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
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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
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21. I attended the deceased from 9-9-61 to 10-10-61 and last saw her him alive on 10-10-61  
 Death occurred at 3:10 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Charles D. Forde M.D.</u>	22b. ADDRESS <u>2601 N. Whittier St.</u>	22c. DATE SIGNED <u>10-11-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bright Way</u>	23b. DATE <u>10 14 61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sweet-home Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sweet-home ark</u>
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24. FUNERAL DIRECTOR ADDRESS <u>A.H. Burks 3901 Ashland</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 13 1961</u>	26. REGISTRAR'S SIGNATURE <u>Paul Smith M.D.</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Lery A Bonnieter*

Licensed Embalmer No. *4523*

P. O. Address *4251 Washing*

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.