

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046844

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

12455

STATE FILE NUMBER

AMENDED

FILED JAN 11 1962

Primary Registration District No.

Registrar's No.

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Infirmery			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 4155 Shreve Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle J. Last Scott				4. DATE OF DEATH Month December Day 30, Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1876	9. AGE (last birthday) 85	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Memphis, Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Thomas Johnson			13b. MOTHER'S MAIDEN NAME Mary Lester		14. NAME OF HUSBAND OR WIFE James W. Scott		
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. None		17. INFORMANT Address M. Del Gratia Scott, 4155 Shreve 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) Cerebral Embolism						INTERVAL BETWEEN ONSET AND DEATH 7 days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Mural Thrombi						unknown	
DUE TO (c) Arteriosclerotic Heart Disease						unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200					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		
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.) 4200					
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 1959 to 12/30/61 and last saw him alive on 12/30/61 . Death occurred at 11:15 am on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Sydney A. Frasse M.D. (Degree or title)				22b. ADDRESS 4901 A Boston		22c. DATE SIGNED 1/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-2-62	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) Rockford, Ill.		(State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd. ADDRESS			25. DATE RECD. BY LOCAL REG. JAN 3 1962		26. REGISTRAR'S SIGNATURE Lois Smith, M.D.		

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis

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.