OCT 2 1927

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

25416

1. PLACE OF DEATH
County: St Louis Mo
Township: Gravoitte
City: Rock Mo (No. Rock Rock Hospital St. Ward)
Registration District No. 1123
Primary Registration District No. 5248 B
File No.
Registered No. 319

2. FULL NAME: Mickey Scott
(a) Residence. No. 9 D K D. 10th St., 3 Ward. St Louis Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 1 yrs. 8 mos. 16 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Ephant. Scott

6. DATE OF BIRTH (MONTH, DAY AND YEAR): 12-10-1899

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
27	8	16	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

PARENTS
10. NAME OF FATHER: Geo Houston
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mississippi
12. MAIDEN NAME OF MOTHER: Lulla Stoppes
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

14. INFORMANT: Rec'd Rob. Rock Hospital
(Address): Rock Mo.

15. FILED Sept. 2, 1927 L. C. Chorck REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 8-26 1927

17. I HEREBY CERTIFY, That I attended deceased from 12-22, 1926, to 8-26, 1927, that I last saw h. alive on 8-26, 1927, and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Pulmonary Tuberculosis
31 7.3.H
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY): None
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Unknown
DID AN OPERATION PRECEDE DEATH? No. DATE OF
WAS THERE AN AUTOPSY? Yes
WHAT TEST CONFIRMED DIAGNOSIS? X Ray Sputum
(Signed) B. Eleen, M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Greenwood Cemetery
DATE OF BURIAL: 9/3 1927

20. UNDERTAKER: Dunn Bros
ADDRESS: 2155 S. Jefferson ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD