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

Do not use this space.

8977

1. PLACE OF DEATH

County ..... Registration District No. 791 1003 File No. .....

Township ..... Primary Registration District No. ..... Registered No. 2689

City St. Louis Mo. (No. Buder Building 7th, & Market St. ..... Ward)

2. FULL NAME Wm. McClelland Scott.

(a) Residence. No. 3425 Juniata St., 16 Ward. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
Male	White	Widower.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 7/13/1863

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	65	7	14	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stationary Fireman.

(b) General nature of industry, business, or establishment in which employed (or employer) Buder Building.

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ohio.

PARENTS

10. NAME OF FATHER William Scott.

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known.

12. MAIDEN NAME OF MOTHER Not Known.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Not Known.

14. INFORMANT Mrs Hazel Lloyd
(Address) 3425 Juniata St

15. FILED 3 28 19 Max C. Starkey REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/27/29 19

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 2.50 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
131
93C (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Chronic Parenchymatous Nephritis (duration) ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED?

IF NOT AT PLACE OF DEATH? 1240

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) J. W. Kemer M.D.

2/28, 1929 (Address) Dep. Coron

*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	DATE OF BURIAL
Valhalla	Mch 2 1929

20. UNDERTAKER	ADDRESS
Provost Und Co	3710 N Grand

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.