

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 30216

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1565

1. PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Overland  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town Overland  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3540 Gordon Ave.  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME

Bert W. Scott.  
307  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day \_\_\_\_\_  
year 1939 hour 10 AM minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
that I last saw him alive on \_\_\_\_\_  
and that death occurred on the date and hour stated above.

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of ~~husband's~~ wife Anna C. Scott. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 8, 1869.  
(Month) (Day) (Year)

Immediate cause of death  
chronic myocarditis  
chronic nephritis 5 yrs  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
70 1 24 hr. \_\_\_\_\_ min.

Other conditions (Include pregnancy within 3 months of death)  
Major findings: Of operations 131  
Of autopsy no

9. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter (retired)

11. Industry or business \_\_\_\_\_

12. Name John Scott.

13. Birthplace Ireland.

14. Maiden name Marie A. Goodfellow.

15. Birthplace St. Louis, Missouri.  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Miss June A. Scott.  
(b) Address 3540 Gordon Ave.

17. (a) Burial (b) Date thereof 9-4-1939.  
(Burial, cremation, entombment) (Month) (Day) (Year)  
(c) Place: burial Memorial Park Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.  
(b) Address 5966-68 Boston Ave.

19. (a) SEP 4 1939 (b) D. R. Meyer, M.D.  
(Date received local registrar) (Registrar's signature)

PHYSICIAN  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) no  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

28. Signature Dr. Schumacher (M. D. or other)  
Address 8816 Webster Rd Date signed 9-4-39

**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 3454

David C. Gibson, Registered Apprentice No. ....  
working under my personal supervision.

Signed David C. Gibson

Licensed Embalmer No. 3454

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**