

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9062**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **1 mo. 13 days**
(Specify whether
In this community **15 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis** (If outside city or town limits, write "RURAL")
(d) Street No. **2220 Franklin** (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Hattie Scott

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Female** 5. Color of race **Negro** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Dec 25 1903**
(Month) (Day) (Year)

8. AGE: Years **39** Months **9** Days **13** If less than one day _____ hr. _____ min.

9. Birthplace **Ark 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **House wife**

11. Industry or business

12. Name **Walter Fisher**
13. Birthplace **Ark 1**
(City, town, or county) (State or foreign country)
14. Maiden name **Cattie Hugh**
15. Birthplace **Ark 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **Johannie C. 194**

(b) Address **2220 Franklin**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-13-43**
(Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **F. G. Green**

(b) Address **2915 Franklin Ave**

19. (a) **OCT 13 1943** (Date received local registrar)

J. J. Boudrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **8**, year **1943** hour **6** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **August 25, 1943** to **October 8, 1943**; that I last saw her alive on **October 8, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Chr. Glomerulonephritis** Duration **Indef.**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(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) Years of injury **0**

23. Signature **G. M. Jackson** (M. D. or other) _____

Address **6601 W. 11th St.** Date signed **10/11/43**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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.....

....., Registered Apprentice No.

working under my personal supervision.

Signed *J. A. Green*

Licensed Embalmer No. *2963*

P. O. Address *2915 Franklin Ave*

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 this body is not embalmed, fact should be so stated above.