

Registration District No.

Primary Registration District No. 1000 00.

Registrar's No.

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:
Mo. Baptist Hospital
(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 Mo (b) County St. Louis
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5337 Bladstone Place
(If rural, give location)
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME Sandra Bee Scott

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex girl 5. Color or race white 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 March 4 - 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 1 If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Charles Watson Scott
13. Birthplace Worcester Mass.
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth K. Wagner
15. Birthplace Perryville Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mo. Baptist Hospital
(b) Address 919 N. Taylor

17. (a) BURIAL (b) Date thereof March 6 - 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MEMORIAL PK. CEM.

18. (a) Signature of funeral director A. Muller
(b) Address 516 S. Delmar St.

19. (a) MAD (b) J. J. Bruesch
(Date received by local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 5
year 1944 hour 5 minute 35 P.M.
21. I hereby certify that I attended the deceased from MARCH 4/6
1944 to MARCH 5 1944
that I last saw her alive on MARCH 5 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Atelectasis

Due to PRE MATURITY

Due to _____

Other conditions (Include pregnancy within 3 months of death) 159

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)
(f) Means of injury 3

23. Signature John B. Orpell (M. D. or other)
Address 1222 Missouri Trust Date signed 3/6/44

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

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

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.....

Licensed Embalmer No.....

P. O. Address.....

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.