

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20263

State File No. _____

FILED JUN 30 1944

1003

Registrar's No. 5590

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Route City Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME ~~Thomas D. Scott~~ Thomas D. Scott

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Feb. 22 1944
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

3 28 hr. min.

9. Birthplace Little Rock Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Marvin H. Scott

{ 13. Birthplace Greenbriar Arkansas
(City, town, or county) (State or foreign country)

{ 14. Maiden name Margie L. Scott

{ 15. Birthplace California
(City, town, or county) (State or foreign country)

16. (a) Informant Marvin H. Scott

(b) Address 600 E. 15th St., Little Rock Ark.

17. (a) Removal (b) Date thereof June 23-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Rock Ark.

18. (a) Signature of funeral director Wm. J. Robert L. & U. C. Mo.

(b) Address 1905 S. Grand, St. Louis

19. (a) JUN 21 1944 J. F. Bredes
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4050 Castleman Ave
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 20
year 1944 hour 12 minute 0 M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Allectious Premature

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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) _____

(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? _____

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature Alfred Perry (M. D. or other) _____

Address _____ Date signed 6/20/44

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

Elvin C. Lacy
working under my personal supervision.

Registered Apprentice No. *368*

Signed *John Ketter*
Licensed Embalmer No. *3880*
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.