

No. 2  
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5-17-39  
K37823

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED MAY 12 1945

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11765

Registration District No.

318

Primary Registration District No.

1003

State File No.

Registrar's No.

3572

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
(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 17 days  
In this community 40 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 13  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4016a Fairfax  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Edward Scott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 5. Color or race CO  
6. (a) Single, widowed, married, divorced Divorced  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: April 27 1879  
(Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 24  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Unknown OKL 1  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER  
12. Name John Scott  
13. Birthplace OKL 1  
(City, town, or county) (State or foreign country)  
14. Maiden name Margaret Scott  
15. Birthplace OKL 1  
(City, town, or county) (State or foreign country)

16. (a) Informant Cecil Scott  
(b) Address 4526 New Berry Terr  
17. (a) Burial (b) Date thereof 4-23-45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Greenwood Cem

18. (a) Signature of funeral director Miss Fun Home  
(b) Address 2828 S. Stoddard St  
19. (a) APR 23 1945 J. J. Bredeck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 20,  
year 1945 hour 10 minute 40 P.M.

21. I hereby certify that I attended the deceased from April  
3, 1945 to April 20, 1945;  
that I last saw him alive on April 20, 1945;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Pulmonary Tuberculosis Duration Unk.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) 1/3 1/2

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_  
23. Signature B. F. Murphy (M. D. or other) 4/21/45  
Address 260 W. Hubbard Date signed \_\_\_\_\_

(Licensed Embalmer's Statement on Reverse Side)

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 L. Boylan  
....., Registered Apprentice No. 000  
working under my personal supervision.

Signed Lorraine Boylan  
Licensed Embalmer No. 2946  
P. O. Address St Louis, Mo

**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.**

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St Louis  
(b) City or town St Louis  
(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)

3. (a) PRINT FULL NAME Edward Scott

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced div

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

7. Birth date of deceased April 27 (Month) (Day) (Year)

8. AGE: Years 65 Months 11 Days 28 If less than one day \_\_\_\_\_ min.

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

10. Usual occupation Ret

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

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) MAY 18 1945 (Date received local registrar) J. F. Buseck (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

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

SUPPLEMENTARY

11.765