

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3958**

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:
Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **68 days**
(Specify whether _____)

In this community _____
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. **2310 Chestnut** (last address)
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **Pete Scott**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April 13** day **13**
year **1946** hour **4** minute **55 A** M.

4. Sex **Male** 2

5. Color or race **Negro**

6. (a) Single, widowed, married, divorced **Wid. 2**

6. (b) Name of husband or wife **Unknown**

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

7. Birth date of deceased **Feb. 18**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Feb. 6** 19**46** to **April 13** 19**46**;
that I last saw him alive on **April 13** 19**46**;
and that death occurred on the date and hour stated above.

8. AGE: **abt. 83**
Years Months Days If less than one day
hr. min.

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

10. Usual occupation **Laborer**

Immediate cause of death: **Senile Psychosis (2) Hypertensive Heart Disease with Uremia**

Duration **Unk.**

11. Industry or business _____

12. Name **Ike Scott**

13. Birthplace **Tenn.**
(City, town, or county) (State or foreign country)

14. Maiden name **Eva Scott**

15. Birthplace **??**
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions **Syphilis**
(Include pregnancy within 3 months of death)

Physician **Unk.**

MOTHER FATHER

16. (a) Informant **Elizabeth Hardiman**
2601 N Whittier

17. (a) **Anatomical Board** (b) Date thereof **MAY 1 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Anatomical Board**

18. (a) Signature of funeral director **W. Richter**
3500 Rutgers

(b) Address _____

19. (a) **MAY 1 1946** (b) **J. F. Bessick**
(Date received local registration) (Registrar's signature)

Major findings:
Of operations _____

Of autopsy **None**

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) (e) Means of injury _____

23. Signature **H. J. Erwin** (M. D. or other) _____
Address **2601 N Whittier** Date signed **4/15/46**

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

14552

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.