

FILED MAY 27 1946

Registration District No. **377**

Primary Registration District No. **6076**

1. PLACE OF DEATH:

(a) County **St. Louis**

(b) City or town **Lemay**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Torrence Home 128 E. Etta ave.
(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 **Margaret S. Scott**

3. (b) If veteran, name war **no**

3. (c) Social Security No. **no**

4. Sex **Female** 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 **October 16 1872**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
73	7	1	hr. _____ min. _____

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

10. Usual occupation **Nil**

11. Industry or business _____

MOTHER { 12. Name **John Scott**

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

14. Maiden name **Mary Ann Goodfellow**

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

16. (a) Informant **Jube Scott**

(b) Address **1919 Natural Bridge ave.**

17. (a) **Burial** (b) Date thereof **May 20-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Peters Cemetery**

18. (a) Signature of funeral director **C. Hoffmeister Colonial Mortuary**

(b) Address **646 Chippewa st.**

19. (a) **5-20-46** (b) **E. J. Miller**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **Lemay**
(If outside city or town limits, write "RURAL")

(d) Street No. **128 E. Etta ave.**
(If rural, give location)

(e) Citizen of foreign country? **no** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **17**
year **1946** hour **3** minute **50 P.** M.

21. I hereby certify that I attended the deceased from **1 Feb 1946**, 19____ to **17 May 1946**, 19____
that I last saw h. & R. alive on **17 May 1946**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Cornary Occlusion & Congestive High Failure 4 mos+

Due to **Chronic Myocarditis**
Chronic Endocarditis

Due to **Aneurysmal Fibulation**

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

Duration

PHYSICIAN

Major findings:
Of operations _____

Of autopsy _____

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?

23. Signature **William F. McClary MD**
While at work? _____ (Specify type of place) (c) Means of injury _____

Address **3615 S. Grand Blvd** Date signed **18 May 46**

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

*Write name of
3615 S Broad
2-4
PL 5733
No. PL 2577*

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 *Linus C. Hoffmeyer*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

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.