DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18890

FILED MAY 31 1946

Registration District No. 318 Primary Registration District No. 1005 Registrar's No. 4603

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 Phillips 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 Missouri (b) County St. Louis

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

(d) Street No. 4125 W. Belle Pl.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME ROBERT DAN SCOTT

3. (b) If veteran, name war #1

3. (c) Social Security No. --

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife ANNA

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Aug. (Month) 31 (Day) 1895 (Year)

8. AGE: Years 50 | Months 8 | Days 19 | If less than one day ____ hr. ____ min.

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

10. Usual occupation Chauffeur

11. Industry or business --

MOTHER FATHER

12. Name John E. Scott

13. Birthplace Unavailable (City, town, or county) Mo. (State or foreign country)

14. Maiden name Emma Williams

15. Birthplace Herine (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Anna Scott

(b) Address 4125 W. Belle

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-24-46 (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Ave.

19. (a) MAY 22 1946 (Date received local registrar) J. F. Bueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20th year 1946 hour 4 minute 25 A. 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 Cerebral Hemorrhage — Duration

Due to 8 3a

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 (M. D. or other)

Address Date signed 5/22/46

(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.....

Thomas J. Gates, Registered Apprentice No.....,

working under my personal supervision.

Signed Thos J Gates

Licensed Embalmer No. 4259

P. O. Address 4107 Finney Ave.

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.