No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29478

FILED SEP 2 1947

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8012

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: 817 N. 18th. St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

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. 817 N. 18th. St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME THOMAS W. SCALES
3. (b) If veteran, name war
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 SALLIE SCALES 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased JULY (Month) 4 (Day) 1871 (Year)

8. AGE: Years 76 Months 1 Days 16 If less than one day hr. min.

9. Birthplace LIVINGSTON (City, town, or county) ALA (State or foreign country)
10. Usual occupation LABORER
11. Industry or business

FATHER
12. Name WILLIAM SCALES
13. Birthplace LIVINGSTON (City, town, or county) ALA (State or foreign country)

MOTHER
14. Maiden name Indiana
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Sallie Scales
(b) Address 817 N 18th St.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 1947 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters
18. (a) Signature of funeral director Floyd English
(b) Address 2221 Lucas ave
19. (a) AUG 24 1947 (Date received local registrar) (b) J. F. Bradley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 24 year 1947 hour minute 8:40 M.
21. I hereby certify that I attended the deceased from 8-1, 1947, to 8-21, 1947, that I last saw him alive on 8/21, 1947, and that death occurred on the date and hour stated above.

Duration

Immediate cause of death Carcinoma of stomach
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy NO

PHYSICIAN
Underline the cause of 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 822 N. Jefferson Date signed 8/25/47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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.