S. No. 2
DM—5-43
v. 5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 2 1947

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29503

Primary Registration District No. 1003

Registrar's No. 7959

1. PLACE OF DEATH:

(a) County
(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: 5412 Cabanne /
(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 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 5412 Cabanne 9
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME John William Scott

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M. 0

5. Color or race W.

6. (a) Single, widowed, married, divorced D. 2

6. (b) Name of husband or wife

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

7. Birth date of deceased July 14 (Month) 1881 (Day) (Year)

8. AGE: Years 66 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Grandview, Ind. (City, town, or county) / (State or foreign country)

10. Usual occupation Retired

11. Industry or business

MOTHER FATHER

12. Name Wm. John Scott /

13. Birthplace Wheeling W. Va. (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name Mary J. Anderson

15. Birthplace near Grandview, Ind. / (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. G. B. Lindsay
(b) Address 5412 Cabanne

17. (a) cremation (Burial, cremation, or removal) (b) Date thereof Aug. 23-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Valhalla

18. (a) Signature of funeral director Alexander Sons
(b) Address 6175 Delmar

19. (a) AUG 22 1947 (Date received local registrar) (b) J. F. Broderick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21
year 1947 hour 7: minute 00 P. M.

21. I hereby certify that I attended the deceased from Aug. 20, 1940, to Aug. 20, 1947, that I last saw him alive on Aug. 20, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral hemorrhage	1 da.
Due to: Cerebral hemorrhage old right hemiplegia	12 years.
Due to: Cerebral arteriosclerosis	12 years.
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 N. J. Eversoll (M. D. or other) M.D.
Address 6256 Clayton Road Date signed 8-22-47

(Licensed Embalmer's Statement on Reverse Side)

Dr. Emanuel
6356 Clayton
Hosp. 11-12-3-6 1944.
St. 4060

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 Thomas R. Kenwick

Licensed Embalmer No. 3793

P. O. Address 6175 Delmar

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.