

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21328**
6014

FILED JUL 15 1948

Registration District No. **318**

Primary Registration District No. **1005**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis
(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 26 hours (Specify whether
In this community 28 years (Specify whether
years, months or days)

3: (a) PRINT FULL NAME Cora Scott

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Female 5. Color or race Col.

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased December 17 1879
(Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Vicksburg Miss
(City, town, or county) (State or foreign country)

10. Usual occupation domestic

11. Industry or business _____

12. Name Will Brown

13. Birthplace New Orleans La.
(City, town, or county) (State or foreign country)

14. Maiden name Bertha Johnson

15. Birthplace New Orleans La.
(City, town, or county) (State or foreign country)

16. (a) Informant Evelyn Hill

(b) Address 4569 Kensington Pl.

17. (a) Burial (b) Date thereof 7-8-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director: Ellis Funeral Home

(b) Address 2820 Stoddard St.

19. (a) JUL 7 1948 J. F. Breese
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County ool
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4569 Kensington
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1
year 1948 hour 7 minute 40 p. M.

21. I hereby certify that I attended the deceased from June 30, 19 48, to July 1, 19 48
that I last saw her or alive on July 1, 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death Lungs -- Bronchial Pneumonia Duration _____
Kidneys -- Pyelonephritis Undet.

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy Yes

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? _____

While a _____ (Specify type of place)
(e) Means of injury _____

23. Signature Charles R. Froese (M. D. or other) _____

Address 2601 N. Whittier Date signed 7/3/48

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 *Fulton E. Bulkin*

Licensed Embalmer No. *4198*

P. O. Address *St Louis 13 Mo*

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.