

FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39614

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>2002</u>		State File No. <u>3069</u>		Registrar's No. <u>4304</u>			
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri.</u> b. COUNTY <u>St. Louis,</u>							
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>RICHMOND HEIGHTS</u>				c. LENGTH OF STAY (If this place) <u>6 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>University City 5,</u>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. MARYS HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>7251 Cornell Avenue,</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>ALICE</u>			b. (Middle) <u>LORETTA.</u>		c. (Last) <u>SCOTT.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 1, 1949.</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 13, 1881.</u>		9. AGE (In years last birthday) <u>68.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home..</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.,</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Lawrence M. Piper.</u>				13b. MOTHER'S MAIDEN NAME <u>Ann McInenery.</u>			14. NAME OF HUSBAND OR WIFE <u>Dr. George B. Scott.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>		16. SOCIAL SECURITY NO. <u>no.</u>		17. INFORMANT'S SIGNATURE OR NAME: ADDRESS <u>Dr Geo. B. Scott, 7251 Cornell Ave.,</u>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8-10 yrs</u> <u>331X</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>331X</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____			21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____						
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____					
22. I hereby certify that I attended the deceased from <u>Sept 1944</u> to <u>Nov 1, 1949</u> , that I last saw the deceased alive on <u>Nov 1, 1949</u> , and that death occurred at <u>4:45 P. M.</u> , from the causes and on the date stated above.											
23a. SIGNATURE <u>Ed Kramer M.D.</u> (Degree or title)					23b. ADDRESS <u>6347 Grand</u>			23c. DATE SIGNED <u>11-2-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>11/4/1949</u>		24c. NAME OF CEMETERY OR CREMATORY. <u>Calvary Cemetery.</u>			24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>11-2-49</u>		REGISTRAR'S SIGNATURE <u>Herbert W. Wombe M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.R. Lupton & Sons; 7233 Delmar Blvd.,</u>						

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

Arnold W. Schoene

Licensed Embalmer No. *3864*

P. O. Address, *St. Louis, 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.