

FILED JUN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 18640

318

1003

4662

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4950 Lindell Blvd.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2129	
		d. STREET ADDRESS (If rural, give location) 4950 Lindell Blvd.	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Ruth	b. (Middle) M.	c. (Last) Scott	May 25, 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Aug. 25, 1868		9. AGE (In years last birthday) Months Days 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa	
				12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Aaron Hinsdale		13b. MOTHER'S MAIDEN NAME Sarah Hoffman		14. NAME OF HUSBAND OR WIFE Walter S. Scott	
15. WAS DECEASED EVER IN U.S. ARMY, NAVY, AIR FORCE, OR MARINE CORPS? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. H. W. Simpkins, 4950 Lindell Blvd.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral atherosclerosis</i>		DUPLICATE (b) <i>juvenile arteriosclerosis</i>			6 months	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUPLICATE (c) <i>hypertension</i>				
II. OTHER SIGNIFICANT CONDITIONS (Conditions contributing to the death but not related to the disease or condition causing death.)						

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input 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?		332X	

22. I hereby certify that I attended the deceased from April 26, 1949, to May 25, 1950, that I last saw the deceased alive on May 24, 1950, and that death occurred at 5 p. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>J. B. Foster</i>		23b. ADDRESS 3903 Olive St.		23c. DATE SIGNED May 26, 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-27-50		24c. NAME OF CEMETERY OR CREMATORY Bellefontaine	
				24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. MAY 26 1950		REGISTRAR'S SIGNATURE <i>J. B. Foster</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wagoner Mortuary, 4911 Washington Blv	
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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 J. Wm Bumpley

Licensed Embalmer No. 3653

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.