U.S. No. 300
Rev. 10.48

FILED OCT 15 1953

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 34027

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8758

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo.
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Kentucky
b. COUNTY: Marshall Co.
c. CITY OR TOWN: Benton
d. Is Residence within limits of a city or incorporated town? Yes X No
e. STREET ADDRESS (If rural, give location): 8160 8

3. NAME OF DECEASED (Type or Print)
a. (First): Edwin
b. (Middle): M.
c. (Last): Scott

4. DATE OF DEATH (Month) (Day) (Year): Sept. 9, 1953.

5. SEX: Male 0
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 7, 1904
9. AGE (In years last birthday): 49. If under 1 year: Months / Days. If under 1 hr.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Keeper
10b. KIND OF BUSINESS OR INDUSTRY: United Eng. Const.
11. BIRTHPLACE (City and State or Foreign Country): Abbyville La.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Unknown
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: Pauline Scott.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Pauline Scott Benton Ky.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Thrombosis, spontaneous, internal cerebral left
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Anoxia, left cerebral hemisphere 2 days
brain sec. to 1.
DUE TO (c): Hypertension, arterial

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 week

19a. DATE OF OPERATION: 9/9/53
19b. MAJOR FINDINGS OF OPERATION: Insufficient blood supply left hemisphere brain
20. AUTOPSY? YES ☐ NO ☒

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): 332X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-8, 1953, *to* 9-9, 1953, *that I last saw the deceased alive on* 9-9, 1953, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George E. Ronchee MD
23b. ADDRESS: 3720 Washington Ave. St. Louis Mo.
23c. DATE SIGNED: 9/9/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-9-53
24c. NAME OF CEMETERY OR CREMATORY: Local
24d. LOCATION (City, town, or county) (State): Benton Ky.

DATE REC'D BY LOCAL REG.: SEP 9 1953
REGISTRAR'S SIGNATURE: J. Carl Smith MD MPD
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Albert H. Hoppe 4700 Washington Blvd

(Licensed Embalmer's Statement on Reverse Side)

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1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN
c. LENGTH OF STAY (In this place)
c. CITY OR TOWN
d. If Residence within limits of a city or incorporated town? Yes ☐ No ☐

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
e. STREET ADDRESS (If rural, give location)

VS JUN 2 1960

3. DATE OF DEATH (Month) (Day) (Year)
a. (First)
b. (Middle)
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year)

5. AGE (In years, not birthday)
6. DATE OF BIRTH
7. COLOR OR RACE
8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
9. DATE OF BIRTH
10. SEX
11. BIRTHPLACE (City and State or Foreign Country)
12. CITIZEN OF WHAT COUNTRY?
13. KIND OF BUSINESS OR INDUSTRY
14. NAME OF HUSBAND OR WIFE
15. MOTHER'S MAIDEN NAME
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME
ADDRESS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalm

by me, or by ..... Student Embalmer No. .....

working under my personal supervision..

Student ..... Signed John S. Denne

Signature of Student Embalmer

Licensed Embalmer No. 4194

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failu to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.