

STANDARD CERTIFICATE OF DEATH

455556

FILED JAN 19 1954

1003

State File No.

12058

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

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY HOSPITAL		e. STREET ADDRESS (If rural, give location) 4180 FARLIN AVE.	

3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) W. c. (Last) SCOTT		4. DATE OF DEATH (Month) (Day) (Year) 12 20 53	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 9 - 8 - 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY INT. DECORATOR	9. AGE (In years last birthday) 69
		11. BIRTHPLACE (City and State or Foreign Country) HIGHLAND, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME UNKNOWN	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE KATE SCOTT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME KATE SCOTT ADDRESS 4180 FARLIN AVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral apoplexy				4 hours
ANTECEDENT CAUSES		DUE TO (b) Asthenia Sclerotic		6 yrs
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Aortic Stenosis		6 yrs
II. OTHER SIGNIFICANT CONDITIONS		Myocardial Infarction		6 yrs

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 411X

22. I hereby certify that I attended the deceased from **Jan**, 19**47**, to **Dec**, 19**53** that I last saw the deceased alive on **12/20/1953** and that death occurred at **7** **P** m., from the causes and on the date stated above.

22a. SIGNATURE Malind D. Glawer (Degree or title) _____	23b. ADDRESS 506 Olive St	23c. DATE SIGNED 12/22/53
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 12 - 23 - 53	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI
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DATE REC'D BY LOCAL REG. DEC 22 1953	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE STROOT CARROLL ADDRESS 4600 NAT. BRIDGE
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(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.....
Signature of Student Embalmer

Signed..... *M W Ruster*

Licensed Embalmer No... *486*

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

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting. ,
If this body is not embalmed, fact should be so stated above.