

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 22 1954

State File No. 39228
Registrar's No. 9995

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9995	
1. PLACE OF DEATH a. COUNTY <u>MISSOURI</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>ST LOUIS, MO.</u>		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 <u>MISSOURI PACIFIC HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>3315 HICKORY</u> 21690			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JANIE</u>		b. (Middle) _____		c. (Last) <u>SCOTT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 31 54</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>DEC. 2, 1920</u>	
9. AGE (In years last birthday) <u>33</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Little Rock, Ark.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ralph Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Rosa Thomas</u>		14. NAME OF HUSBAND OR WIFE <u>George Scott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If res. give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>George Scott 3315 Hickory St.</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>Congestive Heart Failure</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH* _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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. HOW DID INJURY OCCUR? <u>443x</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <u>Oct 25, 1954</u> to <u>Oct 31, 1954</u> , that I last saw the deceased alive on <u>Oct 31, 1954</u> and that death occurred at <u>1201</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>[Signature]</u>		(Degree or title) _____		23b. ADDRESS <u>M. W. 1703 S. Grand</u>		23c. DATE SIGNED <u>11-1-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>Nov. 4, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>DeValls Bluff, Arkansas</u>	
DATE REC'D BY LOCAL REG. <u>NOV 3 1954</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. H. RANDLE & SON 3133 Bell Ave</u>			

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 *D. J. Watson*

Licensed Embalmer No. *269*

P. O. Address *2769 dha*

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.