

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42803

State File No. \_\_\_\_\_  
Registrar's No. 10906

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis Mo.</u>		c. LENGTH OF STAY (in this place) <u>2 yrs.</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		2139
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>			d. STREET ADDRESS (If rural, give location) <u>13 5100 Arsenal St.</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>CALEB</u> b. (Middle) <u>WILLIAM</u> c. (Last) <u>SCOTT</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 21 1954</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/9/76</u>	9. AGE (in years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>12</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Allison Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>		14. NAME OF HUSBAND OR WIFE <u>Ruth Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>493005-7785</u>	17. INFORMANT'S SIGNATURE OR NAME <u>C. Robinson</u>		ADDRESS <u>5100 Arsenal 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute hemorrhagic Pancreatitis</u>  ANTECEDENT CAUSES DUE TO (b) <u>Bilateral Pneumonitis</u> <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) <u>Arteriosclerotic heart disease c</u> II. OTHER SIGNIFICANT CONDITIONS <u>chronic pericarditis - chronic brain syndrome</u> <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <u>4 yrs. x</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11/15/54</u>
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. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>4200</u>				
22. I hereby certify that I attended the deceased from <u>Sept 29</u> , 19 <u>52</u> , to <u>Nov. 21</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>Nov. 21</u> , 1952, and that death occurred at <u>7:00A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>R. H. Valler</u> (Name or title) <u>M.D.</u>		23b. ADDRESS <u>5100 Arsenal St.</u>		23c. DATE SIGNED <u>11/23/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <u>11-31-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>NOV 30 1954</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rowland-Aker Mortuary Service</u> ADDRESS _____		

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

*W. E. Eubank*

Licensed Embalmer No. \_\_\_\_\_

*2222*

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.