

FILED AUG 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28145**
Registrar's No. **6406**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 6406	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 15 days		c. CITY OR TOWN Lemay 850		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: Alexian Bros. Hospital				e. STREET ADDRESS (If rural, give location) 124 Sigsbee			
3. NAME OF DECEASED (Type or Print) a. (First) Samuel b. (Middle) J. c. (Last) Scott Sr.			4. DATE OF DEATH (Month) (Day) (Year) July 25, 1955				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH June 4, 1895	
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent		10b. KIND OF BUSINESS OR INDUSTRY National Lead Co.		11. BIRTHPLACE (City and State or Foreign Country) Missouri	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henry Scott		13b. MOTHER'S MAIDEN NAME Mary Odell	
13a. FATHER'S NAME Henry Scott		13b. MOTHER'S MAIDEN NAME Mary Odell		14. NAME OF HUSBAND OR WIFE Clara Schlierhoff Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW # 1		16. SOCIAL SECURITY NO. 497-03-5600		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Scott 124 Sigsbee Lemay 23 Mo.			
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) Intestinal obstruction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of colon DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 153K				INTERVAL BETWEEN ONSET AND DEATH 6 weeks 1 year	
19a. DATE OF OPERATION July 10, 55		19b. MAJOR FINDINGS OF OPERATION Annular Carcinoma hepatic flexure of colon				20. AUTOPSY? - YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., to 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?			
22. I hereby certify that I attended the deceased from June 19 1955 , to July 25 1955 , that I last saw the deceased alive on July 24 1955 , and that death occurred at 12:10A m. , from the causes and on the date stated above.							
23a. SIGNATURE Ray C. Ruppel M.D.		(Degree or title)		23b. ADDRESS 7702 Lavery Ave		23c. DATE SIGNED 7/25/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE July 28, 1955		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		24d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Road	
DATE REC'D BY LOCAL REG. JUL 25 1955		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hoffmeister U. & L. Co. 7811 S. Broadway St. Louis 11 Mo.			

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 *Louis C. Hoffmeister*.....

Licensed Embalmer No. 38.....

P. O. Address 7814 S. B.....

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.