

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3078

FILED JAN 29 1957

Registration District No. **318** Primary Registration District No. **1003** STATE FILE NUMBER **230** Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Length of stay in lb	d. STREET ADDRESS 2729 Mills			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Beatrice Middle Last Scott				4. DATE OF DEATH Month 1 Day 5 Year 57			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR 22-88		9. AGE (In years last birthday) 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) ST LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME Josephine Tandy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Wm Scott 2729 Mill St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Right						INTERVAL BETWEEN ONSET AND DEATH undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)		332xH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Retroperitoneal Neurogenic Sarcoma - Carcinoma of Cervix (Old)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from 12-19-56 to 1-3-57 and last saw her alive on 1-5-57 Death occurred at 1:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE: Frank O. Richards, M.D. (Degree or title)				22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 1-7-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 1-11-57	23c. NAME OF CEMETERY OR CREMATORY GREENWOOD CEM. WELLSVILLE		23d. LOCATION (City, town, or county) (State) MO		
24. FUNERAL DIRECTOR A.F. Walton 2707 Stoddard St.				25. DATE RECD. BY LOCAL REG. JAN 9 57		26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.	

S.P.

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 *H. Claude Gordon*

Licensed Embalmer No. *34*

P. O. Address *4575 A*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.