

Health,
Welfare
Public
Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26551

STATE FILE NUMBER

FILED JUL 26 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar **6363**

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 checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 38 enroute City Hospital		Length of stay in 1b 40 yrs 9/8	d. STREET ADDRESS (If outside, give location) 4202 W. Pine		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Leila Middle Scott Last Scott			4. DATE OF DEATH Month July Day 6 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1895	9. AGE (In years last birthday) 61 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS.: _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paymistress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	11. BIRTHPLACE (City and state or country) Alton Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles Boersker			14. MOTHER'S MAIDEN NAME Dora Springer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yrs. no. or unknown) (If yrs. give war or dates of service) no		16. SOCIAL SECURITY NO. 489-05-5414	17. INFORMANT Address LaVerne Wichmann 1944 Dodier 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 Apoplexy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH
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.) 334x			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ 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 _____, to _____ and last saw her alive on _____ Death occurred at 11:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Wm. J. Morrell			22b. ADDRESS 1500 Elvree		22c. DATE SIGNED 7/9/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7/10/57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.		23d. LOCATION (City, town, or county) Normandy Missouri
24. FUNERAL DIRECTOR ADDRESS Wm. J. Morrell 3710 N. Grand Blvd.		25. DATE RECD. BY LOCAL REG. JUL 9 57		26. REGISTRAR'S SIGNATURE J. Carl Smith MD <i>mks</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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 *Stanley H. Dip...*

Licensed Embalmer No. *41*

P. O. Address *St. L.*

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.