

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034683
STATE FILE NUMBER

FILED OCT 10 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9409

300
1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <u>ST LOUIS CITY HOSP. #1</u> INSTITUTION			Length of stay in lb <u>lifetime</u>		d. STREET ADDRESS (If outside, give location) <u>1019 N. 7th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle Last <u>SCOTT</u>				4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>58</u>					
5. SEX <u>Male 2</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1912</u>		9. AGE (In years last birthday) <u>45</u> IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Walter Scott</u>			13b. MOTHER'S MAIDEN NAME <u>Katie Childs</u>			14. NAME OF HUSBAND OR WIFE <u>nil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes WW2</u>			16. SOCIAL SECURITY NO. <u>489-18-9387</u>		17. INFORMANT Address <u>Katie Scott 1019 N. 7th Street</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMOPERICARDIUM</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>DISSECTING ANEURISM</u>									
DUE TO (c) <u>451X</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. Month, Day, Year									
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <u>9/26/58</u> to <u>9/28/58</u> and last saw her alive on <u>9/28/58</u> Death occurred at <u>9-28-58 9P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>A. J. Greenbank</u> (Degree or title) <u>M. D.</u>			22b. ADDRESS <u>1515 LAFAYETTE</u>			22c. DATE SIGNED <u>9-30-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE <u>10-3-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National, Jefferson Bks.</u>		23d. LOCATION (City, town, or county) (State) <u>Jefferson Barracks, Mo.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>Dement & Son 2629-31 Cole St.</u>				25. DATE RECD. BY LOCAL REG. <u>OCT 1 '58</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith MD</u>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *W. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.