

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046258

STATE FILE NUMBER

FILED DEC 22 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar N. 1768

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 causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residency before admission) a. STATE <u>Illinois</u> b. COUNTY	
b. CITY (If outside corporate limits; give TOWNSHIP only) OR TOWN <u>St Louis</u>		c. CITY OR TOWN <u>Granite City</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>40 St Louis Little Rock Hosp Inc</u>		d. STREET ADDRESS (If outside, give location) <u>32 2411 Missouri Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Louis</u> Last <u>Scantling</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22, 1883</u>
9. AGE (In years last birthday) <u>75</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penr Switchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>
11. BIRTHPLACE (City and state or country) <u>RICHMOND, MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN SCANTLING</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA NOEL</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>702,12,6293</u>	17. INFORMANT <u>Nellie Scantling</u> Address
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>Carcinoma of nasopharynx with metastases</u> 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) <u>146X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
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 _____ 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 <u>Oct 16 58</u> to <u>Dec 6, 58</u> and last saw <u>her</u> alive on <u>Dec 5, 1958</u> Death occurred at <u>6:00 am</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Dr. M. T. Anderson M.D.</u>		22b. ADDRESS <u>1755 So Grand</u>	
22c. DATE SIGNED <u>Dec 6, 1958</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-9-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET HILL</u>	23d. LOCATION (City, town, or county) (State) <u>EDWARDSVILLE, ILLINOIS</u>
24. FUNERAL DIRECTOR <u>Frank Mercer</u> ADDRESS <u>Granite City</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 8 '58</u>	
26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u>		M. J. B.	

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 *Kinston C. Skillian*

Licensed Embalmer No. 501

P. O. Address GRANITE CITY

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.