

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023381  
STATE FILE NUMBER  
25667

FILED JUL 1 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ky. 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 Louisville
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Hospital		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 3716 S. Wicks, Str.
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Scott			4. DATE OF DEATH Month Day Year June 13, 1959
5. SEX Male	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 4/25/1916
9. AGE (In years last birthday) 43		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) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Jefferson County, Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Henton Scott	13b. MOTHER'S MAIDEN NAME Fannie ?
14. NAME OF HUSBAND OR WIFE Maggie L. Scott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (unknown)) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. 419-18-0180
17. INFORMANT Maggie L. Scott, Louisville, Ky.		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) <i>Intra cranial hemorrhage</i> <i>causid by</i> DUE TO (b) <i>Fractured Skull</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <i>902.645</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal condition stated in PART I (a) <i>Subdural in fall</i> <i>withdrawing of second floor</i> <i>902.645</i>			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT, SUICIDE, HOMICIDE <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <i>Open</i> <i>Verdict</i>		
20c. TIME OF INJURY Hour Month, Day, Year 9:30 p.m. 6 1959		20b. HOW INJURY OCCURRED (If not noted in injury in PART I or PART II in (a) or (b)) <i>at the Hotel, about 9:30 p.m. June 13 1959</i> <i>cause and manner of same could not be determined</i>	
20d. INJURY OCCURRED WHILE AT WORK <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.) 113	20f. CITY AND COUNTY LOCATION, Ferdinand STATE <i>St. Louis Mo</i>	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Paul Simon Koroner</i>		22b. ADDRESS <i>1300 Clark</i>	22c. DATE SIGNED <i>6/15/59</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6/16/1959	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Louisville, Ky.
24. FUNERAL DIRECTOR Peoples Und.Co. 3100 Franklin Ave.		25. DATE RECD. BY LOCAL REG. JUN 15 '59	26. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

VS JUL 7 1959

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. C. ...*

Licensed Embalmer No. *3470*  
P. O. Address *1173 ...*

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.