

# MARI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 11 1960

~~60-008855~~  
STATE FILE NUMBER  
**60-008855**

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2-2350**

<b>1. PLACE OF DEATH</b> a. COUNTY _____  b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b> Length of stay in 1b _____  c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>DePaul Hospital</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____  c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>  d. STREET ADDRESS (If outside, give location) <b>3417 Osage Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>RICHARD</b> Middle <b>J.</b> Last <b>SCOTT</b>			<b>4. DATE OF DEATH</b> Month <b>Feb.</b> Day <b>28</b> Year <b>1960</b>				
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. Married</b> <input checked="" type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>10-31-1889</b>	<b>9. AGE (last birthday)</b> <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Grocer-Self Employed (Retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Grocery</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>St. Louis, Mo.</b>		<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>	

<b>13a. FATHER'S NAME</b> <b>Peter Scott</b>	<b>13b. MOTHER'S MAIDEN NAME</b> <b>Louise Dewalle</b>	<b>14. NAME OF HUSBAND OR WIFE</b> <b>Myra Scott</b>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War 1</b>		<b>16. SOCIAL SECURITY NO.</b> <b>499-36-9806</b>
<b>17. INFORMANT</b> <b>Myra Scott</b>		<b>Address</b> <b>3417 Osage Ave.</b>

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <i>Coronary Arteriosclerosis</i> <b>A.S.H.D.</b> DUE TO (b) <b>A.S.H.D.</b> DUE TO (c) <b>420.0</b>  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH  _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m.		Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		COUNTY _____ STATE _____	

**21. I attended the deceased from** 1/14/60 to 2/28/60 and last saw <sup>her</sup>him alive on 2/9/60  
 Death occurred at 6:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> (Degree or title) <b>Franklin P. Knight M.D.</b>		<b>22b. ADDRESS</b> <b>10011 Bellefontaine Rd</b>		<b>22c. DATE SIGNED</b> <b>2/19/60</b>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Removal</b>	<b>23b. DATE</b> <b>March 2, 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Memorial Park Cemetery</b>	<b>23d. LOCATION</b> (City, town, or county) (State) <b>St. Louis Co. Mo.</b>	
<b>24. FUNERAL DIRECTOR</b> <b>Kriegshauser 4228 S. Kingshighway Blvd.</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>FEB 29 1960</b>		<b>26. REGISTRAR'S SIGNATURE</b> <b>Carl Smith, M.D.</b>

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed William B White

Licensed Embalmer No. 4291

P. O. Address 4228 So. 1st

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.