

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS APR 4 1960

2 3031 60-013190  
STATE FILE NUMBER

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 <b>Missouri</b> b. COUNTY <b>St. Louis</b>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>4 days</b>		c. CITY OR TOWN <b>Maplewood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Anthony's Hospital</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>7605 Alicia</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>B.</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>15th</b> Year <b>1960</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <b>5-31-1890</b>		9. AGE (last birthday) <b>69</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never Employed</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Martin, Tenn.</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>					
13a. FATHER'S NAME <b>Charles Scott</b>				13b. MOTHER'S MAIDEN NAME <b>Unknown</b>				14. NAME OF HUSBAND OR WIFE <b>Oda Scott</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>494-09-8602</b>		17. INFORMANT <b>Oda Scott</b>		Address <b>Above</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE POST. MYOCARDIAL INFARCTION</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										<b>8 YRS.</b>			
DUE TO (c) <b>420.0</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1) Bronchial Asthma 2) Diabetes Mellitus</b>								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					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 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 <b>5-4-50</b> to <b>7-15-66</b> and last saw <sup>him</sup> alive on <b>3-14-66</b> Death occurred at <b>7:15 a.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Henry Hooper M.D.</b>						22b. ADDRESS <b>818 Olive St.</b>			22c. DATE SIGNED <b>3/15/60</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>3-17-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>				23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>					
24. FUNERAL DIRECTOR <b>JAY B. SMITH, Maplewood, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 15 1960</b>		26. REGISTRAR'S SIGNATURE <b>Keal 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 A. Burgess

Licensed Embalmer No. 402

P. O. Address Maple

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.