

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-014750

FILED VS. APR 18 1960

Registration District No. 115-116 Primary Registration District No. 3020 Registrar's No. 79

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Franklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Franklin</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Washington</u>		Length of stay in 1b <u>1 dy</u>		c. CITY OR TOWN <u>St. Clair</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Francis Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Rieker Ford Road</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Francis</u> Last <u>Scully</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</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>9/22/84</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ert. Elevator Operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (City and state or country) <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>John Scully</u>			13b. MOTHER'S MAIDEN NAME <u>Bridget</u>			14. NAME OF HUSBAND OR WIFE <u>Hilda Scully</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>488 01 5527</u>		17. INFORMANT <u>Hilda Scully</u>		Address <u>St. Clair, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia.</u>							<u>3 days.</u>		
DUE TO (b) <u>Cardiac decompensation</u>							<u>? weeks</u>		
DUE TO (c) <u>Arterio-sclerotic C-V. Disease</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>General infirmities of old age</u>							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 <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 April 60</u> , to <u>10 April 60</u> and last saw ^{her} him alive on <u>10 Apr 60</u> Death occurred at <u>10:40 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>R. B. Boyd, M.D.</u>				22b. ADDRESS <u>Washington, Mo.</u>			22c. DATE SIGNED <u>11 Apr 60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>4/12/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u>		(State)		
24. FUNERAL DIRECTOR <u>Casey Lenox</u>			ADDRESS <u>St. Clair, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4/11/60</u>	26. REGISTRAR'S SIGNATURE <u>R. B. Boyd</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 19 1960

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

R. M. Lenz

Licensed Embalmer, No.

3601

P. O. Address

St. Clair, Mo

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.