

COURT DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH															
FILED VS MAR 13 1961 318															
Registration District No. 318				Primary Registration District No. 1003				Registrar's No. 1958							
-61-011556 STATE FILE NUMBER															
AMENDED															
DATE AMENDED															
INSTEAD OF															
DOCUMENT															
BY AFFIDAVIT OF															
ITEM NO. SHOULD READ															
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri.</b>						Length of stay in 1b			c. CITY OR TOWN <b>St Louis 34</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>DePaul Hospital</b>						Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			d. STREET ADDRESS (If outside, give location) <b>9009 Trefore</b>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)						First <b>Frank</b>			Middle <b>Scott</b>			Last			
4. DATE OF DEATH						Month <b>Feb.</b>			Day <b>25</b>			Year <b>1961</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>Feb. 11 14</b>		9. AGE (last birthday) <b>47</b>		IF UNDER 1 YEAR Months <b>14</b>		IF UNDER 24 HR Days <b>14</b> Hours <b>14</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Supt.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Husmann Roper</b>				11. BIRTHPLACE (City and state or country) <b>Gal Conda, Ill</b>				12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13a. FATHER'S NAME <b>John Scott</b>				13b. MOTHER'S MAIDEN NAME <b>Millissa James</b>				14. NAME OF HUSBAND OR WIFE <b>Margaret 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>						17. INFORMANT Address <b>Margaret Scott 9009 Trefore St. Louis 14, Mo</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>Hemorrhage, acute esophageal varices</b>															
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cirrhosis of liver.</b>															
DUE TO (c) <b>581.0</b>															
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							
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 <b>June 1959</b> to <b>Feb. 25 1961</b> and last saw <sup>him</sup> him alive on <b>Feb 24, 1961</b> . Death occurred at <b>4:00 am</b> m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE <b>John E. Shaner M.D.</b> (Degree or title)						22b. ADDRESS <b>Northland Med Bldg</b>			22c. DATE SIGNED <b>2/25/61</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>2/28/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>				23d. LOCATION (City, town or county) <b>St Louis County, Mo</b>		(State)					
24. FUNERAL DIRECTOR <b>Ortmann F Home 9222 Lackland Overland Mo</b> ADDRESS					25. DATE RECD. BY LOCAL REG. <b>FEB 27 1961</b>			26. REGISTRAR'S SIGNATURE <b>Earl Smith M.D.</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 Al C. Ortman

Licensed Embalmer No. 3478

P. O. Address \_\_\_\_\_

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.