

**SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-61-016035**

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1229

FILED MAY 8 1961

1. PLACE OF DEATH a. COUNTY <u>ST Loui's</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLinois</u> b. COUNTY <u>Greene</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>OAKLAND</u>	Length of stay in 1b <u>WKS.</u>	c. CITY OR TOWN <u>Road house</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Bethesda Dillworth Home</u>		d. STREET ADDRESS (If outside, give location) <u>221 E. PALM Ave</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>D.</u> Last <u>SCOTT</u>			4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-1879</u>	9. AGE (last birthday) <u>82</u>	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) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ALton ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		

13a. FATHER'S NAME <u>Ralph Dixon</u>		13b. MOTHER'S MAIDEN NAME <u>Lydia Barnes</u>		14. NAME OF HUSBAND OR WIFE <u>FRANK SCOTT</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>None</u>		17. INFORMANT Address <u>FRANK S. SCOTT Webster Groves</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
DUE TO (b) <u>Arteriosclerotic thrombotic disease</u>		
DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		

19. WAS AUTOPSY PERFORMED? YES <input 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.)	
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20c. TIME OF INJURY Hour _____ 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.) <u>Feb 15</u>		20f. CITY, TOWN, OR LOCATION _____ COUNTY _____ STATE _____	
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21. I attended the deceased from <u>Feb 15 1961</u> and last saw her alive on <u>May 1 1961</u>	
Death occurred at <u>5 39</u> p.m. on the date stated above, and to the best of my knowledge from the causes stated.	

22a. SIGNATURE (Degree or title) <u>Dr. Webster Groves MD</u>		22b. ADDRESS <u>Webster Groves Mo</u>		22c. DATE SIGNED <u>5/2/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fernwood Cemetery</u>		23d. LOCATION (City, town, or county) <u>Road house ILL.</u> (State)	

24. FUNERAL DIRECTOR <u>Rowland Aker</u> ADDRESS <u>4104 Manchester</u>		25. DATE RECD. BY LOCAL REG. <u>5-2-61</u>		26. REGISTRAR'S SIGNATURE <u>John C. Murphy MD</u>	
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

**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 \_\_\_\_\_ Signed \_\_\_\_\_  
Signature of Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

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.