

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **61-039205**

Registration District No. **318** Primary Registration District **1003** Registrar's No. **9712**

FILED OCT 20 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 21 days	c. CITY 7 OR TOWN East St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospital, Inc.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 667 N. 61st St
3. NAME OF DECEASED (Type or print) First Lee Middle Roy Last Scott		4. DATE OF DEATH Month October Day 20 Year 1961	

5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-6-1891	9. AGE (last birthday) 70	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) Penetr. Switchman	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Eddieville, Ken.	12. CITIZEN OF WHAT COUNTRY USA.
---	--	---	--

13a. FATHER'S NAME William Scott	13b. MOTHER'S MAIDEN NAME Alice Cash	14. NAME OF HUSBAND OR WIFE Sarah
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Sarah Scott 667 N 61 E St
---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. IMMEDIATE CAUSE (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) A.S.H.D.		
DUE TO (c) Nephrosclerosis :4200		

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 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 Oct. 5, 1961 to Oct. 20, 1961 and last saw him/her alive on Oct. 20, 1961 Death occurred at 10:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [Signature] (Degree or title) M.D.	22b. ADDRESS 1755 S. Grand Blvd.	22c. DATE SIGNED 10-20-61
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10-23-61	23c. NAME OF CEMETERY OR CREMATORY OAK GROVE.	23d. LOCATION (City, town, or county) (State) Jerseyville Illinois
--	------------------------------	---	--

24. FUNERAL DIRECTOR Holton Funeral Home, E. St. Louis Ill.	25. DATE RECD. BY LOCAL REG. OCT 21 1961	26. REGISTRAR'S SIGNATURE [Signature]
---	--	---

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 Not Embalmed, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

J. Newey Haller Jr.

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.