

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-042656

STATE FILE NUMBER

FILED NOV 18 1958

Registration District No. 317

Primary Registration District No. 544

Registrar's No. 2900

300  
1-57

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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				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>Kirkwood</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Kirkwood 4713</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. Joseph Hosp.</b>			Length of stay in lb <b>6 days</b>		d. STREET ADDRESS (If outside, give location) <b>402 W. Argonne Dr.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>PRENTISS</b> Middle <b>GALE</b> Last <b>SCUDDER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>9</b> Year <b>1958</b>									
5. SEX <b>Male</b> <input type="checkbox"/>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1913</b>		9. AGE (In years last birthday) <b>45</b>		F UNDER 1 YEAR Months <b>4</b> Days <b>24</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Brightman Distr.</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri</b> <input type="checkbox"/>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Prentiss Gale Scudder</b>				13b. MOTHER'S MAIDEN NAME <b>Clara Hill</b>				14. NAME OF HUSBAND OR WIFE <b>Willette Poole Scudder</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>				16. SOCIAL SECURITY NO. <b>493-07-6135</b>		17. INFORMANT Address <b>Willette Scudder, 402 W. Argonne Dr.</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>Carcinomatosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 Mon.</b>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma Pharynx</b>										6 yrs.			
DUE TO (c) <b>148X</b>													
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 checked="" type="checkbox"/> <b>2</b>			
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 <b></b> Month, Day, Year a.m. <b></b> p.m. <b></b>													
20d. INJURY OCCURRED WHILE AT <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>Nov. 3, '58</b> to <b>Nov. 9, '58</b> and last saw <sup>him</sup> alive on <b>Nov. 9, 1958</b> Death occurred at <b>4:15 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <i>Charles C. Orndorff</i> (Degree or title) <b>MD</b>						22b. ADDRESS <b>19 E. Lockwood</b>			22c. DATE SIGNED <b>11/10/58</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>Nov. 11, 1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery</b>			23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>						
24. FUNERAL DIRECTOR <b>Ambruster Mortuary, 6633 Clayton Rd.</b>						25. DATE RECD. BY LOCAL REG. <b>11-10-58</b>		26. REGISTRAR'S SIGNATURE <i>Herbert R. Donker M.D.</i>					

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.....  
*Fred J. Hamme*

Licensed Embalmer No. *1408*

P. O. Address.....  
*Louis*

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.