

REC'D NOV 7 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

35846
Do not use this space.

1. PLACE OF DEATH

(a) County Clayton Registration District No. 204
 (b) Township Shoal Primary Registration District No. 3013
 (c) City Cameron (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 50

2. PRINT FULL NAME

(a) Residence, No. 540 Clapinda Daniel St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OF RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ar Daniels
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 2-4-1850
 7. AGE YEARS 89 MONTHS 8 DAYS 18 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 23 1939
 22. I HEREBY CERTIFY, That I attended deceased from 10/17, 1939, to 10/21, 1939
 I last saw her alive on 10/21, 1939. Death is said to have occurred on the date stated above, at 3 A. m.
 The principal cause of death and related causes of importance were as follows:

Cerebral apoplexy
Chronic hypertensive
arteriosclerosis
 Date of onset 10/17/39
 Other contributory causes of importance: 101

12. BIRTHPLACE (CITY OR TOWN) Scottsville (STATE OR COUNTRY) Ind.

FATHER 13. NAME Reason Scott
 14. BIRTHPLACE (CITY OR TOWN) Ind. (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME Elizabeth Unknown
 16. BIRTHPLACE (CITY OR TOWN) Ind. (STATE OR COUNTRY)

17. INFORMANT Reason McCutchan (ADDRESS) Hamilton Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE Delano DATE Oct 24 1939

19. FUNERAL DIRECTOR (NAME) Q. Moore (ADDRESS) Cameron Mo

20. FILED Oct 23 1939 St. B. Riley Local Registrar

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) D. Bloom, D. O. M. D.
 (Address) Cameron, Mo.

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Court Room No. 117

District File No. 1129-1430

Date Filed NOV 3 1939

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,

C. Moore

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

C. Moore

Licensed Embalmer No. 1180

P. O. Address *Cameron, 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 this body is not embalmed, above space should be left blank.