CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Pulaski

Township ~~Cullen~~

or

Village Waynesville,

or

City _____ (NO. _____ _____ St.: _____ Ward)

Registration District No. 713 File No. 38879

Primary Registration District No. 4478 Registered No. 33

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Bland Creecy Scott.

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Single

DATE OF BIRTH: October 9th (Month) (Day), 1911 (Year)

AGE: 2 yrs. — mos. 19 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: XXXXXXXXXXXXXXXXXXX
(b) General nature of industry, business, or establishment in which employed (or employer): XXXXXXXXXXXXXX

BIRTHPLACE (City or town, State or foreign country): Waynesville, Mo.

PARENTS

NAME OF FATHER: Fred L. Scott.

BIRTHPLACE OF FATHER (City or town, State or foreign country): Dixon, Mo.

MAIDEN NAME OF MOTHER: Nellie Anderson

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Howell, Co.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred L. Scott

(ADDRESS) Waynesville Mo

Filed Nov. 6, 1911 [signature] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: October 28th, (Month) (Day), 1911 (Year)

I HEREBY CERTIFY, that I attended deceased from October 24th 1911, to October 28th 1911, that I last saw him alive on October 28th, 1911, and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Diptheria

10 [illegible]

(Duration) — yrs. — mos. 4 ds.

Contributory (SECONDARY) Unknown

(Duration) — yrs. — mos. — ds.

(Signed) L. Tice M. D.

Nov. 1st 1911 (Address) Waynesville, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 4 yrs. — mos. 19 ds. In the State 4 yrs. — mos. 19 ds.

Where was disease contracted if not at place of death? Place of Death

Former or usual residence unknown

PLACE OF BURIAL OR REMOVAL: Dixon Mo.

DATE OF BURIAL: Oct. 29th 1911

UNDERTAKER: J. B. Christeson

ADDRESS: Waynesville,

PLACE OF DEATH

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

County.....

Township ..... Registration District No..... File No.....

or

Village..... Primary Registration District No..... Registered No.....

or

City .....(NO..... , ...St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., *1*.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191....., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., *191*.....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191....., to....., 191....., that I last saw h.....alive on....., 191....., and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.

....., 191..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191.....
UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.