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.

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

PLACE OF DEATH

County: Pettis

Township: ~~Sedalia~~

or Village:

or City: 2 ward Sedalia

Registration District No. 668 — File No. 23585

Primary Registration District No. 3032 — Registered No. 170

St.: Ward)

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

FULL NAME: William Wesley Scott

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

COLOR OR RACE: White

SINGLE — MARRIED — WIDOWED — OR DIVORCED — (Write the word) S

DATE OF BIRTH: Feby 12 (Month) 1914 (Day), 1 (Year)

AGE: yrs. 5 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): Sedalia Mo

PARENTS

NAME OF FATHER: J W Scott

BIRTHPLACE OF FATHER (City or town, State or foreign country): Cole County Mo

MAIDEN NAME OF MOTHER: Ida Bell Hohimer

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Delaway Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): W Scott

(ADDRESS): North Hurley St

Filed: July 18, 1914 — F. B. Long, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: July 10 (Month) (Day), 1914 (Year)

I HEREBY CERTIFY, that I attended deceased from July 3, 1914, to July 3, 1914, that I last saw him alive on July 3, 1914, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Illeacolitis

119B 104

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E. A. Stuart M. D.

July 18, 1914 (Address) 104 [illegible]

*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: Crown Hill

DATE OF BURIAL: July 10 1914

UNDERTAKER: McLaughlin Bros

ADDRESS: Sedalia Mo

PLACE OF DEATH

County _____

Township _____
or
Village _____
or
City _____ (NO. _____ St.: _____ Ward)

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

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[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

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 import