

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

Do not use this space.

Address
9835

1. PLACE OF DEATH

County *Miller*
Township *Cedar*
City *Cedar* (No. _____)

Registration District No. *561*
Primary Registration District No. *4330*

File No. _____
Registered No. *26*
St. _____ Ward _____

2. FULL NAME

Chas. H. Scott
(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Married*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Berte Lee Scott*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan 19 1888*

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. min.
40 1 16

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Painter*
(b) General nature of industry, business, or establishment in which employed (or employer) *House Painter*
(c) Name of employer *DeVane*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

PARENTS

10. NAME OF FATHER *W.H. Scott*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

12. MAIDEN NAME OF MOTHER *Not known*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

14. INFORMANT *Berte Lee Scott*
(Address) *Cedar*

15. FILED *4-10 1928* *Belle Haynes*
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9 7 1928*

17. I HEREBY CERTIFY, That I attended deceased from *Jan 1 1928* to *3-6 1928* that I last saw him alive on *3-6 1928* and that death occurred, on the date stated above, at *2-6 p.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Hogchinson disease

CONTRIBUTORY (SECONDARY) *65 P*
(duration) _____ yrs. _____ mos. _____ da.

18. WHERE WAS DISEASE CONTRACTED *65 P*
IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH: _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS: *Waller*
(Signed) _____, M. D.
, 19 _____ (Address) *Elden Miss*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *mt Pleasant Cemetery* DATE OF BURIAL *8/7 1928*

20. UNDERTAKER *Wm Phillips* ADDRESS *Edgar*

M. 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.

APR 10 1928

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