

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

Do not use this space.

15071

1. PLACE OF DEATH

County.....

Registration District No. **791**

File No.

Township.....

Primary Registration District No. **1003**

Registered No. **3989**

City.....

(No. **2322** Division **St.**)

St.

Ward)

2. FULL NAME

(a) Residence. No. **2322** Division **St.** **21** 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.

ds.

How long in U.S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX

Male

4. COLOR OR RACE

Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Virginia Scott

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan. 20, 1880

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

48

2

17

8. OCCUPATION OF DECEASED

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

laborer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

Kansas City, Missouri

10. NAME OF FATHER

John Scott

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Kansas City, Missouri

12. MAIDEN NAME OF MOTHER

Ellen Young

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Paris, Kentucky

14. INFORMANT

(Address)

Virginia Scott, 2322 Division St.

15. FILED

NOV 11 1928

Max C. Farley

REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR) *4-7-1928*

17.

I HEREBY CERTIFY, That I attended deceased from *2:00* to *7:00* P.M., to *April 7th*, 1928, and that I last saw him alive on *April 7th*, 1928, and that death occurred, on the date stated above, at *7:12 P.M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

apoplexy (Cerebral Hemorrhage)

87th 74th (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH.....

DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)

James T. Aldrich, M. D.

, Is

(Address) *St. Louis*

*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

DATE OF BURIAL

Washington Park

4-12-1928

20. UNDERTAKER

ADDRESS

Book's United Frankl Ave

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.

WHILE FILLING IN THIS FORM, WITH UNFADING INK—THIS IS A PERMANENT RECORD

