

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

Do not use this space.

16987

1. PLACE OF DEATH

County Stoddard
Township Pickens
City (No.)

Registration District No. 834
Primary Registration District No. 6101

File No.
Registered No. #720

2. FULL NAME

Clarine 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
1 Month None None

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

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

10. NAME OF FATHER Tommy Scott

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

12. MAIDEN NAME OF MOTHER Sallie Nelson

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

14. INFORMANT Jim Taylor
(Address) Essex Ave RI

15. FILED 4/6, 1924 J.P. Brantley REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-5 1929

17. I HEREBY CERTIFY, That I attended deceased from 4-4 1929 to 4-5 1929 that I last saw him alive on 4-4 1929, and that death occurred, on the date stated above, at 8:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Broncho - Pneumonia
V 107A
(duration) yrs. mos. 9 ds.

CONTRIBUTORY (SECONDARY) ✓
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED home
IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? no DATE OF

WAS THERE AN AUTOPSY? ✓
WHAT TEST CONFIRMED DIAGNOSIS? —
(Signed) M. J. [unclear], M. D.
, 19 (Address)

*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.

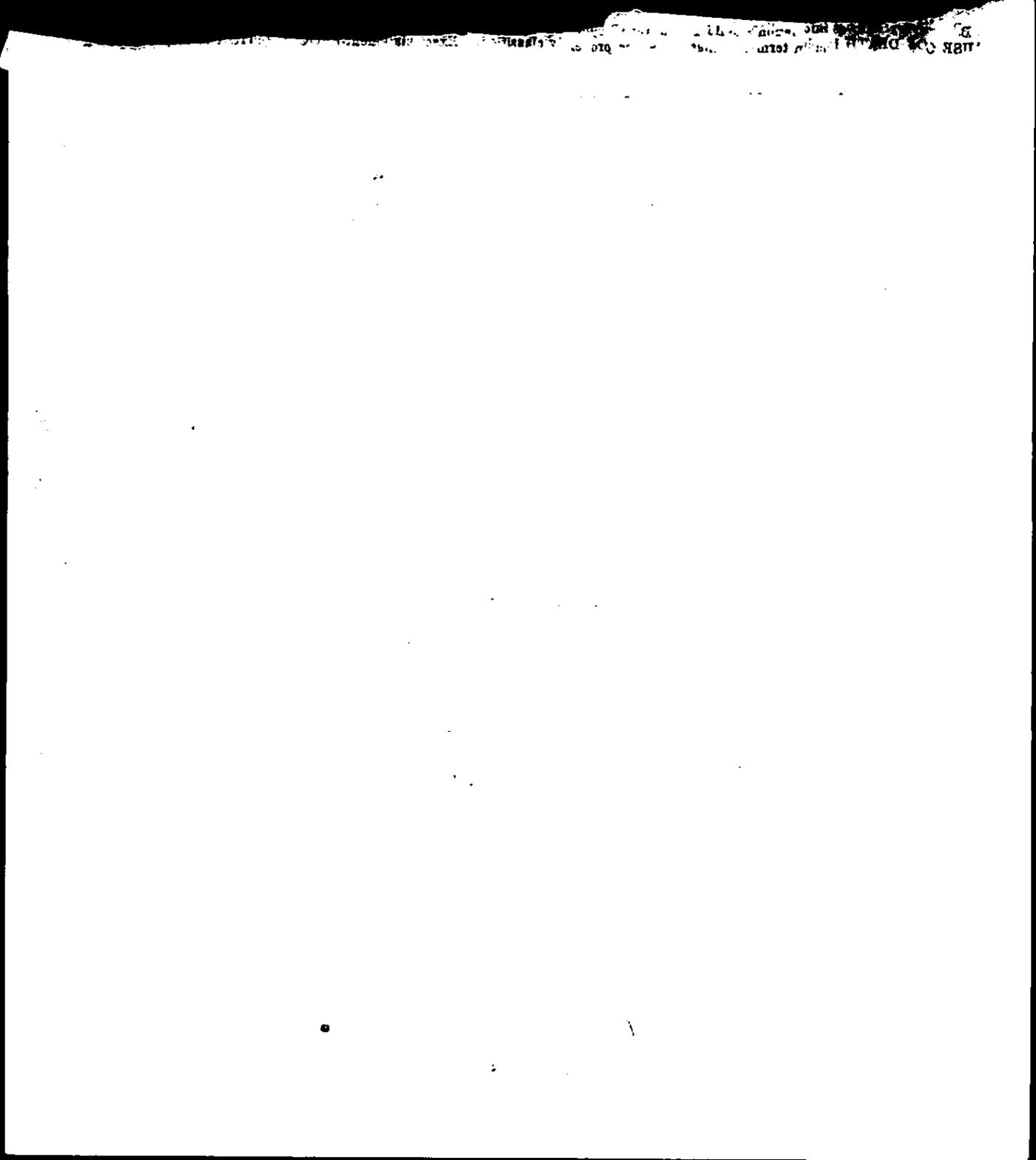
19. PLACE OF BURIAL, CREMATION, OR REMOVAL Nexley Cem. DATE OF BURIAL 4-6 1929

20. UNDERTAKER none ADDRESS —

N. B.—Every item of information should be carefully checked for accuracy. Exact statement of cause of death in plain terms, so that it may be properly classified.

29 1929

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Stoddard Registration District No. 839 File No. _____
Township Richard Primary Registration District No. 6101 Registered No. 21
City _____ (No. _____) St. _____ Ward _____

2. FULL NAME

Clarine 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE @ 5. SINGLE, MARRIED, WIDOWED OR DIVORCED W
(write the word)

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

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

10. NAME OF FATHER _____

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

12. MAIDEN NAME OF MOTHER _____

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

14. INFORMANT _____
(Address) _____

15. FILED 6/8/24 J.P. Brandon
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4-5-1929

17. I HEREBY CERTIFY that I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchopneumonia
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY (SECONDARY) 1000W
(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) _____, M. D.

, 19 _____ (Address)

*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 _____ 19 _____

20. UNDERTAKER _____ ADDRESS _____

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

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 indicated. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-16987