

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

Do not use this space.

**JUN 26 1929**

18645

**1. PLACE OF DEATH**

County Lafayette  
Township Clay  
City Scott No. 0 Ward Archer

Registration District No. 466  
Primary Registration District No. 1627, B

File No. ....  
Registered No. 9  
St. .... Ward)

**2. FULL NAME**

Scott O Archer

(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) Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 12<sup>th</sup> 1868

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or ... min.  
61 | | 30

**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) Ohio

**10. NAME OF FATHER**

No Information

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

(STATE OR COUNTRY) No Information

**12. MAIDEN NAME OF MOTHER**

No Information

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

(STATE OR COUNTRY) No Information

**14.**

INFORMANT Ed Creigs  
(Address) Wellington Mo

**15.**

FILED May 11, 1929 F. W. Mann  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 11<sup>th</sup> 1929

17. I HEREBY CERTIFY, That I attended deceased from May 11<sup>th</sup> 1929 to May 11<sup>th</sup> 1929 that I last saw deceased alive on May 11<sup>th</sup> 1929, and that death occurred, on the date stated above, at 8:00 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Cerebral Hemorrhage  
7513 (duration) yrs. mos. da. Other

CONTRIBUTORY Chronic Alcoholism  
(SECONDARY) (duration) 20 yrs. mos. da.

**18. WHERE WAS DISEASE CONTRACTED**

MIAMI  
IS NOT AT PLACE OF DEATH

18 DID AN OPERATION PRECEDE DEATH? DATE OF .....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? ..  
(Signed) F. W. Mann M. D.  
May 12, 1929 (Address) Wellington Mo

\*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 Green Ridge Mo DATE OF BURIAL May 15 1929

20. UNDERTAKER Cap Bobb ADDRESS Dec Grove

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.

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2  
31  
31

SEP 26 1949