

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

Do not use this space.

25525

**1. PLACE OF DEATH**

County Madison Registration District No. 729 File No. 25525  
 Township Lawton Primary Registration District No. 5-5-8 Registered No. 722  
 City Lawton (No. Lawton P.D.) St. Mo. Ward

**2. FULL NAME**

Egal M. Scott  
 (a) Residence. No. Lawton P.D. St. Mo. 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 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 Maud C. Scott  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) November 1-1879  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
50 8 7               

**8. OCCUPATION OF DECEASED**

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

Louisiana Mo

**10. NAME OF FATHER**

Samuel Scott

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

Louisiana Mo

**12. MAIDEN NAME OF MOTHER**

Martha Turner

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

Louisiana Mo

**14. INFORMANT (Address)**

Maud Scott  
Lawton Mo

**15. FILED**

7-18-1929 J. J. Lawrence REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 8 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1927, to July 8 1929  
 that I last saw him alive on July 5 1929, and that death occurred, on the date stated above, at 10:10 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

diabetes

**CONTRIBUTORY (SECONDARY)**

Diabetes (duration) 2 yrs 6 mos. ds.  
2 (duration) 2 yrs 6 mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT AT PLACE OF DEATH     

DID AN OPERATION PRECEDE DEATH? no DATE OF     

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? general symptoms  
 (Signed) A. H. Phelan, M. D.

7-10, 1929 (Address) Hospital

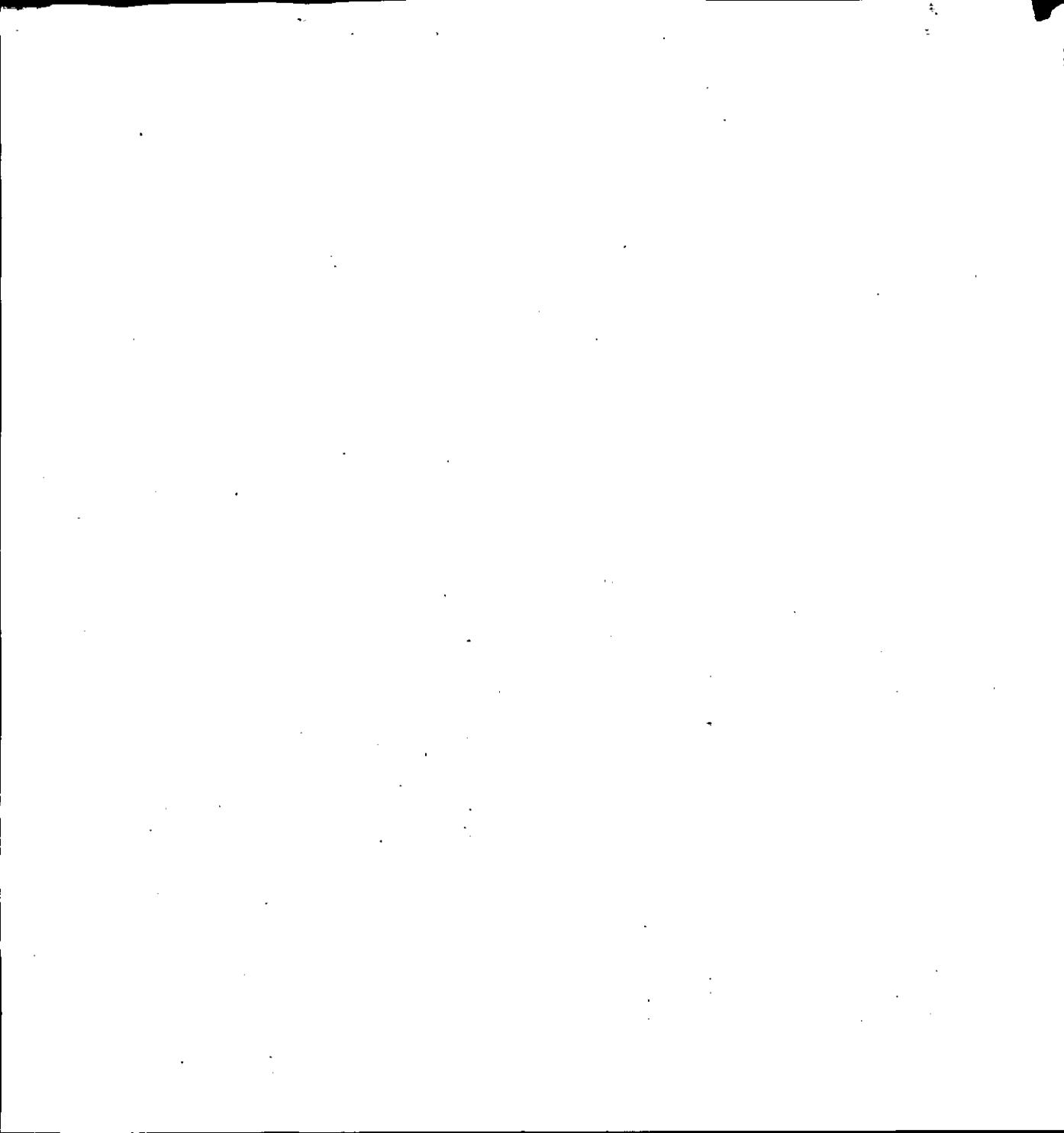
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL**

Lawton P.D. Cemetery July 10 1929

**20. UNDERTAKER**

Wm H. Smith ADDRESS



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH  
 County Saline Registration District No. 726 File No. \_\_\_\_\_  
 Township Saverton Primary Registration District No. 395-8 Registered No. 22  
 City \_\_\_\_\_ (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Earl M 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 1 - 1879

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
49 8 7

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 (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 7-18-29 [Signature] REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) July 8 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:**

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) \_\_\_\_\_, 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 \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE/AS PRESCRIBED BY LAW

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