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

Do not use this space.

38220

1. PLACE OF DEATH
County St Francois — Registration District No. 1115 — File No.
Township [illegible] — Primary Registration District No. 6021 — Registered No. 12
City Womack Mo. (No. ..... St. ..... Ward)

94

2. FULL NAME James 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): married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 10, 1874

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
55	0	9	

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) Minth
(STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER Wm. Scott
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown
12. MAIDEN NAME OF MOTHER Louisa Mead
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Unknown

14. INFORMANT Nora Scott
(Address) Womack, Mo

15. FILED 11/22, 1929 F. G. A. Rydeen REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 19 1929

17. I HEREBY CERTIFY, That I attended deceased from ..... Did not see patient alive
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 2 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Apoplexy
82A
(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (SECONDARY) 7401
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) W. H. Barron, M.D.
11-20, 1929 (Address) Fredricktown 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: Cross Roads, Womack Mo — DATE OF BURIAL: Nov 20 1929

20. UNDERTAKER: Ed. H. Webb, Fredericktown, Mo. — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state AGE should be stated EXACTLY.

31