

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

Do not use this space.

40591

1. PLACE OF DEATH

County Jackson
Township 2
City Kansas City (No. K.C. General Hosp.)

Registration District No. 399
Primary Registration District No. 10

File No. _____
Registered No. 4930
St. _____ Ward _____

2. FULL NAME

Alexander C. Scott

(a) Residence. No. 3744 Chestnut St. 16 Ward.

(Usual place of abode) Length of residence in city or town where death occurred yrs. 3 mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widower

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 1 - 1852

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
77 | 0 | 4

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Traveling salesman
(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) Mo.

10. NAME OF FATHER Thomas Scott

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

12. MAIDEN NAME OF MOTHER Unknown

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

14. INFORMANT Reverend Clerk (Address) K.C. General Hosp.

15. FILED 12-5-29 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-5 1929

17. I HEREBY CERTIFY, That I attended deceased from 12-3, 1929 to 12-5, 1929 that I last saw him alive on 12-5, 1929, and that death occurred, on the date stated above, at 11:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic myocarditis
9:30
9:50

CONTRIBUTORY Acute dilatation of heart (SECONDARY) (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRAICTED 908

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) P. E. Williams, M. D.

12-5, 1929 (Address) Gen Hosp

*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 St. Joseph Mo. DATE OF BURIAL Dec-6-29

20. UNDERTAKER Mrs. C. L. Foster ADDRESS K.C. Mo.

COPIES OF THIS RECORD WILL BE MADE AND FURNISHED TO THE NEAREST RELATIVE OF THE DECEASED.

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.

12-1-136

