MAR 25 1930

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

Do not use this space.

1. PLACE OF DEATH
County Callaway — Registration District No. 104 — File No. 4244
Township — Primary Registration District No. 3008 — Registered No. 48
City Fulton (No. ..... St. ..... Ward)

2. FULL NAME Alonzo Scott
(a) Residence. No. State Hosp #1 St., 15 Ward. (If nonresident, give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. 8 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: colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): married

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

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

7. AGE: YEARS 59+ — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

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)

PARENTS
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 State Hosp records
(Address) Fulton Mo

15. FILED 3-3 1930 R. N. Crews REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to Feb 23, 1930 that I last saw him alive on Feb 23, 1930 and that death occurred, on the date stated above, at 2 5 pm.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
General Paralysis of Insane
83
(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 76
(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? no
WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) D G Devine M. D.
2-23, 1930 (Address) State Hosp 1 Fulton

*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: Kirksville, Mo — DATE OF BURIAL: Mar 5 1930

20. UNDERTAKER: Eli Bell — ADDRESS: Fulton, Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 Callaway — Registration District No. 104 — File No. .....

Township ..... — Primary Registration District No. 3008 — Registered No. 48

City Fulton (No. ....., ... St. ..... Ward)

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

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 ..... Dk
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Dk
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... Dk
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER ..... Dk

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

14. INFORMANT .....
(Address)

15. Apr 15, 1930 R. N. Crews
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 23 1930

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:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

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
	19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

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

N. B.—Every item of information ... be carefully supplied. AGE should be stated EXACTLY. ... CAUSE ... so that it may be properly classified. Exact statement of OCCUP...

S- 4244