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

Do not use this space.

11643

1. PLACE OF DEATH
County Benton — Registration District No. 60 — File No.
Township White — Primary Registration District No. 4035 — Registered No. 293.
City Lincoln (No. ..... St. ..... Ward)

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: white
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) Sept 17 — 1857

7. AGE: Years 72 — Months 7 — Days 1 — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Warsaw
(STATE OR COUNTRY) Missouri

PARENTS
10. NAME OF FATHER Archible Scott
11. BIRTHPLACE OF FATHER (CITY OR TOWN) dont know
(STATE OR COUNTRY) Kentucky
12. MAIDEN NAME OF MOTHER Surnand Gatier
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) dont know
(STATE OR COUNTRY) Kentucky

14. INFORMANT Mary D Scott
(Address) Lincoln Mo

15. FILED May 8, 1930 E. L. Rhodes, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 18 1930

17. HEREBY CERTIFY, That I attended deceased from April 16 1930, to April 18, 1930, that I last saw him alive on April 19, 1930, and that death occurred, on the date stated above, at 9 A.M. P. m.

THE CAUSE OF DEATH WAS AS FOLLOWS: Cerebral Apoplexy.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (SECONDARY) 74a1

(duration) yrs. 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? Physical Exam
(Signed) S. O. Stratton, 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: Lincoln Home, April 20 1930 — DATE OF BURIAL

20. UNDERTAKER: J. B. Calbert — ADDRESS: Lincoln

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.

22 1930