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

Do not use this space.

85

18634

1. PLACE OF DEATH
County: Buchanan
Registration District No.
Township:
Primary Registration District No. 1001
City: St Joseph Mo (No. State Hospital St. Ward)
File No.
Registered No. 655

2. FULL NAME: Norman N. Scott
(a) Residence. No. State Hospital Mo 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: Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): about 1880

7. AGE: YEARS 50 | MONTHS Unknown | 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): Unknown

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Unknown

14. INFORMANT: State Hospital Records
(Address) St Joseph Mo

15. FILED JUN 5 1930 John G. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): June 5 1930

17. I HEREBY CERTIFY, That I attended deceased from May 20, 1930, to June 5, 1930 that I last saw him alive on June 4, 1930, and that death occurred, on the date stated above, at 1:50 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Prostatic Abscess
(Origin unknown)
135 (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (SECONDARY) 135 (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) B. C. Miles, M. D.
June 5, 1930 (Address) St Joseph 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: Oak Grove Mo. | DATE OF BURIAL: 6/6 1930

20. UNDERTAKER: Z O Webb | ADDRESS: Oak Grove Mo

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.

WRITE PLAINLY, WITH BLACK INK—THIS IS A PERMANENT RECORD