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

Do not use this space.

23383

1. PLACE OF DEATH
County Laclede
Township Washington
City ..... (No. ..... St. ..... Ward)

Registration District No. 449
Primary Registration District No. 5612

File No. .....
Registered No. 1587

2. FULL NAME Mary E 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.

AUG 26 1930

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 22 Not Known

7. AGE About 62 YEARS MONTHS Not DAYS Known If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(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) West Va.

PARENTS
10. NAME OF FATHER, J. H. Campbell
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) West Va.
12. MAIDEN NAME OF MOTHER Elizabeth Gibson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) West Va

14. INFORMANT Dick Palmer
(Address) Lebanon Mo

15. FILED 7/18, 1930 J M Billings REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

17. I HEREBY CERTIFY, That I attended deceased from May 1st, 1930, to July 16, 1930, that I last saw her alive on July 10, 1930, and that death occurred, on the date stated above, at 5 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Interial Carcinoma
Stomach
46 B
..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 44 A
..... (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? Physical
(Signed) T H Okaly, M. D.
, 19 (Address) Lebanon 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 New Hope
DATE OF BURIAL 7/18 1930

20. UNDERTAKER Palmer
ADDRESS Lebanon