

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

Do not use this space.

7886

1. PLACE OF DEATH

County Crawford Registration District No. 231
Township Marengo Primary Registration District No. 5314
City (No. _____) St. _____ Ward _____

File No. _____
Registered No. _____

2. FULL NAME

Floyd Ostrom Scott
(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M **4. COLOR OR RACE** W **5. SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
(write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jun 15 - 1894

7. AGE YEARS 38 MONTHS 2 DAYS 12 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) Crawford Co Mo

10. NAME OF FATHER Walter Scott

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Osage Co Mo

12. MAIDEN NAME OF MOTHER Edy Palmer

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Osage Co Mo

14. INFORMANT Nina Scott
(Address) Steelville Mo

15. FILED 3-31-32 L. E. White REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/27-1932

17. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1932, to Mar 27, 1932, that I last saw him alive on Mar 27, 1932 and that death occurred, on the date stated above, at 10-30 A. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Bronchial Pneumonia

!!

10 A

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Influenza

(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) John H. Martyn, M. D.

, 19 32 (Address) Cuba 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 **DATE OF BURIAL**

Liberty Cemetery 3/29 1932

20. UNDERTAKER **ADDRESS**

L. J. Jones Steelville 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.

APR 25 1932

