

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

Do not use this space.

3636

1. PLACE OF DEATH

County Stoddard
Township Liberty
City _____ (No. _____)

Registration District No. 836
Primary Registration District No. 6098a

File No. 1
Registered No. 1
St. _____ Ward _____

2. FULL NAME Scott Hartline

(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 W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 11-1857

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>76</u>	<u>7</u>	<u>20</u>		

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Union Co Ill

13. NAME Jacob Scott

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know

17. INFORMANT Clay Hartline
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bernie Mo DATE 1-2 1934

19. UNDERTAKER B.M. Hopkins
(ADDRESS) Bernie Mo

20. FILED 1/2 1934 Florence Allen
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/1 1934

22. I HEREBY CERTIFY, That I attended deceased from 12-30, 1933, to 1/1, 1934

I last saw him alive on 7/1, 1934 Death is said to have occurred on the date stated above, at 5 a m.

The principal cause of death and related causes of importance were as follows:

Proyochial meningia

Date of onset

Other contributory causes of importance:

Senility

Name of operation _____ Date of _____
What test confirmed diagnosis? Empyema Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 1934

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?
If so, specify _____

(Signed) J. P. Stoddard M. D.
(Address) Bernie, 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.

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