

MAR 23 1937

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

Do not use this space.

7385

## 1. PLACE OF DEATH

County New Madrid  
Township La Font  
City..... (No....., .....St. ....Ward)

Registration District No. 604  
Primary Registration District No. 5798

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

## 2. FULL NAME

Tom 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 <u>Male</u>	4. COLOR OR RACE <u>Black</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>6-24-1864</u>		
7. AGE	YEARS	MONTHS
	<u>73</u>	
		DAYS
		If LESS than 1 day, .....hrs. or .....min.

OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Farmer</u>
	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) Miss.

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ont. Iowa

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Tabb Scott18. BURIAL, CREMATION, OR REMOVAL  
PLACE Sawyer DATE 2-5-193719. UNDERTAKER (ADDRESS) Shelby Bros20. FILED 2/22 1937 Wm. O. Johnson Registrar

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-5-193722. I HEREBY CERTIFY, That I attended deceased from 2/3 1937 to 2/3 1937I last saw him alive on 2-3-1937 Death is said to have occurred on the date stated above, at 4 a. m.

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

Myocardial degeneration

Date of onset

Other contributory causes of importance: 920

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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....., 19.....

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) Shelby Bros , M. D.(Address) Wm. O. Johnson

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.

